Professional Services

This section contains payment policy information for professional services. Many of the policies contain information previously published in Provider Bulletins.

In addition to the policies outlined in this section, all providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules,* Provider Bulletins and Provider Updates. If there are any services, procedures or text contained in the CPT® and HCPCS coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies take precedence (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811 or to the Crime Victims Compensation Program at 1-800-762-3716.

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GENERAL INFORMATION

COVERED SERVICES

The department makes general policy decisions, called medical coverage decisions, to ensure quality of care and prompt treatment of workers. Medical coverage decisions include or exclude a specific health care service as a covered benefit.

Procedure codes listed as not covered in the fee schedules are not covered for the following reasons:

1. The treatment is not safe or effective; or is controversial, obsolete, investigational or experimental.
2. The procedure or service is generally not used to treat industrial injuries or occupational diseases.
3. The procedure or service is payable under another code.

The department may pay for procedures in the first two categories on a case-by-case basis. The health care provider must submit a written request and obtain approval from the department or Self-Insurer prior to performing any procedure in these categories. The written request must contain the reason for the request, the potential risks and expected benefits and the relationship to the accepted condition. The healthcare provider must provide any additional information about the procedure that may be requested by the department or Self-Insurer.

For more information on coverage decisions and covered services, refer to WAC 296-20 sections -01505, -02700 through -02850, -030, -03001, -03002 and -1102.

UNITS OF SERVICE

Payment for billing codes that do not specify a time increment or unit of measure is limited to one unit per day. For example, only one unit is payable for CPT® code 97022, whirlpool therapy, regardless of how long the therapy lasts.

UNLISTED CODES

A covered service or procedure may be provided that does not have a specific code or payment level listed in the fee schedules. When reporting such a service, the appropriate unlisted procedure code may be used and a special report is required as supporting documentation. No additional payment is made for the supporting documentation. Refer to Chapter 296-20 WAC (including the definition section) and to the fee schedules for additional information.

WASHINGTON RBRVS PAYMENT SYSTEM AND POLICIES

The department uses the Resource Based Relative Value Scale (RBRVS) to pay for most professional services. Services priced according to the RBRVS fee schedule have a fee schedule indicator of "R" in the Professional Services Fee Schedule.

BASIS FOR CALCULATING RBRVS PAYMENT LEVELS

RBRVS fee schedule allowances are based on relative value units (RVUs), geographic adjustment factors for Washington State and a conversion factor. The three state agencies (L&I, HCA and DSHS) use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

The primary source for the current RVUs is the 2004 Medicare Physician Fee Schedule Database (MPFSDB), which was published by the Centers for Medicare and Medicaid Services (CMS) in the January 7, 2004 *Federal Register*. The *Federal Register* can be accessed online at http://www.gpoaccess.gov/index.html or can be purchased from the U.S. Government in hard copy, microfiche or disc formats. The *Federal Register* can be ordered from the following addresses:

Superintendent of Documents
PO Box 371954
Pittsburgh, PA 15250-7954

or http://bookstore.gpo.gov/index.html

Under CMS's approach, relative values are assigned to each procedure based on the resources required to perform the procedure, including the work, practice expense and liability insurance (malpractice expense). The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State. The Washington State geographic adjustment factors for July 1, 2004 are: 100.2% of the work component RVU, 101.1% of the practice expense RVU and 80.3% of the malpractice RVU.

To calculate the department's maximum fee for each procedure:

1. Multiply each RVU component by the corresponding geographic adjustment factor,
2. Sum the geographically adjusted RVU components and round the result to the nearest hundredth,
3. Multiply the rounded sum by the department's RBRVS conversion factor (published in WAC 296-20-135) and round to the nearest penny.

The department's maximum fees are published as dollar values in the Professional Services Fee Schedule.

SITE OF SERVICE PAYMENT DIFFERENTIAL

The site of service differential is based on CMS's payment policy and establishes distinct maximum fees for services performed in facility and non-facility settings. The department will pay professional services at the RBRVS rates for facility and non-facility settings based on where the service was performed. Therefore, it is important to **include a valid two-digit place of service code on your bill**.

The department's maximum fees for facility and non-facility settings are published in the Professional Services Fee Schedule.

Services Paid at the RBRVS Rate for Facility Settings

When services are performed in a facility setting, the department makes two payments, one to the professional provider and another to the facility. The payment to the facility includes resource costs such as labor, medical supplies and medical equipment. To avoid duplicate payment of resource costs, these costs are excluded from the RBRVS rates for facility settings.

Professional services will be paid at the RBRVS rate for facility settings when the department also makes a payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for facility settings:

Place of Service Code	Place of Service Description
05	Indian health service free-standing facility
06	Indian health service provider-based facility
07	Tribal 638 free-standing facility
08	Tribal 638 provider-based facility
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room-hospital
24	Ambulatory surgery center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
34	Hospice
41	Ambulance (land)
42	Ambulance (air or water)
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
99	Other unlisted facility
(none)	(Place of service code not supplied)

Remember to include a valid two-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

Services Paid at the RBRVS Rate for Non-Facility Settings

When services are provided in non-facility settings, the professional provider typically bears the costs of labor, medical supplies and medical equipment. These costs are included in the RBRVS rate for non-facility settings.

Professional services will be paid at the RBRVS rate for non-facility settings when the department does not make a separate payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for non-facility settings:

Place of Service Code	Place of Service Description
03	School
04	Homeless shelter
11	Office
12	Home
13	Assisted living facility
14	Group home
15	Mobile unit
20	Urgent care facility
32	Nursing facility
33	Custodial care facility
49	Independent clinic
50	Federally qualified health center
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment center
57	Non-residential substance abuse treatment center
60	Mass immunization center
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Inpatient laboratory

Facilities will be paid at the RBRVS rate for non-facility settings when the department does not make a separate payment directly to the provider of the service.

Remember to include a valid two-digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

EVALUATION AND MANAGEMENT SERVICES (E/M)

NEW AND ESTABLISHED PATIENT

The department uses the CPT® definitions of new and established patients.

If a patient presents with a work related condition and meets the definition of a new patient in a provider's practice, then the appropriate level of a new patient E/M should be billed.

If a patient presents with a work related condition and meets the definition of an established patient in a provider's practice, then the appropriate level of established patient E/M service should be billed, **even if the provider is treating a new work related condition for the first time.**

MEDICAL CARE IN THE HOME OR NURSING HOME

The department allows attending physicians to charge for nursing facility services (CPT® codes 99301-99313), domiciliary, rest home (e.g., boarding home), or custodial care services (CPT® codes 99321-99333) and home services (CPT® codes 99341-99350). The attending physician (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

PROLONGED EVALUATION AND MANAGEMENT

Payment of prolonged E/M (CPT® codes 99354-99357) is allowed with a maximum of three hours per day per patient. These services are payable only when another E/M code is billed on the same day using the following CMS payment criteria:

CPT® Code	Other CPT® Code(s) Required on Same Day
99354	99201-99205, 99212-99215, 99241-99245 or 99324-99350
99355	99354 and one of the E/M codes required for 99354
99356	99221-99223, 99231-99233, 99251-99255, 99261-99263, 99301-99303 or 99311-99313
99357	99356 and one of the E/M codes required for 99356

The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the provider and the patient (whether the service was continuous or not). Prolonged physician services without direct contact (CPT® codes 99358 and 99359) are bundled and are not payable in addition to other E/M codes.

A narrative report is required when billing for prolonged evaluation and management services. See Appendix H for additional information.

PHYSICIAN STANDBY SERVICES

The department pays for physician standby services (CPT® code 99360) when all the following criteria are met:

- Another physician requested the standby service; and
- The standby service involves prolonged physician attendance without direct (face-to-face) patient contact; and
- The standby physician is not concurrently providing care or service to other patients during this period; and
- The standby service does not result in the standby physician's performance of a procedure subject to a "surgical package;" and
- Standby services of 30 minutes or more are provided.

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a full 30 minutes of standby was provided for each unit of service reported. Round all fractions of a 30-minute unit downward.

Justification for the physician standby service must be documented and retained in the provider's office and submitted to the department or Self-Insurer for review upon request.

A narrative report is required when billing for physician standby services.

CASE MANAGEMENT SERVICES

Team conferences (CPT® codes 99361-99362) may be payable when the attending doctor, consultant or psychologist meets with an interdisciplinary team of health professionals, department staff, vocational rehabilitation counselors, nurse case managers, department medical consultants, Self-Insurer representatives or employers. Documentation must include a goal-oriented, time-limited treatment plan covering medical, surgical, vocational or return to work activities, or objective measures of function that allow a determination as to whether a previously created plan is effective in returning the injured worker to an appropriate level of function.

Telephone calls (CPT® codes 99371-99373) are payable only when personally made by the attending doctor, consultant or psychologist. These services are payable when discussing or coordinating care or treatment with the injured worker, department staff, vocational rehabilitation counselors, nurse case managers, department medical consultants, Self-Insurer representatives or employers. Telephone calls for authorization, resolution of billing issues or ordering prescriptions are not payable.

Documentation for case management services (CPT® codes 99361-99373) must include:

- The date, and
- The participants and their titles, and
- The length of the call or visit, and
- The nature of the call or visit, and
- All medical, vocational or return to work decisions made.

Psychiatrists and clinical psychologists may only bill for case management services when also providing consultation or evaluation.

PHYSICIAN CARE PLAN OVERSIGHT

The department allows separate payment for physician care plan oversight services (CPT® codes 99375, 99378 and 99380). Payment is limited to one per attending physician, per patient, per 30-day period. Care plan services (CPT® codes 99374, 99377 and 99379) of less than 30 minutes within a 30-day period are considered part of E/M services and are not separately payable.

Payment for care plan oversight to a physician providing postsurgical care during the postoperative period will be made only if the care plan oversight is documented as unrelated to the surgery, and modifier –24 is used. The attending physician (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

TELECONSULTATIONS

The department has adopted a modified version of CMS's policy on teleconsultations. Teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real-time consultation between the patient, consultant and referring provider. Telephones, faxes and electronic mail systems do not meet the definition of an interactive telecommunication system.

Coverage of Teleconsultations

Teleconsultations are covered in the same manner as face-to-face consultations (refer to WACs 296-20-045 and –051), but in addition, **all** of the following conditions must be met:

- The **consultant** must be a doctor as described in WAC 296-20-01002, which includes a MD, DO, ND, DPM, OD, DMD, DDS or DC. A consulting DC must be an approved consultant with the department; and
- The **referring provider** must be one of the following: MD, DO, ND, DPM, OD, DMD, DDS, DC, ARNP, PA or PhD Clinical Psychologist; and
- The patient must be present at the time of the consultation; and
- The examination of the patient must be under the control of the consultant; and
- The referring provider must be physically present with the patient during the consultation; and
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer; and
- A referring provider who is not the attending must consult with the attending provider before making the referral.

Payment of Teleconsultations

Teleconsultations are paid in a different manner than face-to-face consultations. Also, the department and Self-Insurers pay for teleconsultations in a different manner than CMS. Insurers may directly pay both consultants and referring providers for their services. Insurers will pay according to the following criteria:

- Providers (consulting and/or referring) must append a "GT" modifier to one of the appropriate codes listed in the table below.
- The amount allowable for the appropriate code is the lesser of the billed amount or 75% of the fee schedule amount.
- No separate payment will be made for the review and interpretation of the patient's medical records and/or the required report that must be submitted to the referring provider and to the department.
- No payment is allowed for telephone line charges and facility fees incurred during the teleconsultation.

The Consultant May Bill Codes:	The Referring Provider May Bill Codes:
CPT® codes 99241-99245	CPT® codes 99211-99215
CPT® codes 99251-99255	CPT® codes 99218-99239
CPT® codes 99261-99263	CPT® codes 99301-99313
CPT® codes 99271-99275	CPT® codes 99331-99333
CPT® codes 99241-99244 (DCs, NDs)	CPT® codes 99347-99357
	CPT® codes 99211-99214 (for DCs, NDs)
	CPT® code 90801 (for PhD Clinical Psychologists)

END STAGE RENAL DISEASE (ESRD)

The department follows CMS's policy regarding the use of E/M services along with dialysis services. E/M services (CPT® codes 99231-99233 and 99261-99263) are not payable on the same date as hospital inpatient dialysis (CPT® codes 90935, 90937, 90945 and 90947). These E/M services are bundled in the dialysis service.

Separate billing and payment for an initial hospital visit (CPT® codes 99221-99223), an initial inpatient consultation (CPT® codes 99251-99255) and a hospital discharge service (CPT® code 99238 or 99239) will be allowed when billed on the same date as an inpatient dialysis service.

APHERESIS

The department no longer covers apheresis services. Apheresis is not used to treat industrial injuries or occupational diseases.

SURGERY SERVICES

GLOBAL SURGERY POLICY

Many surgeries have a follow-up period during which charges for normal postoperative care are bundled into the global surgery fee. The global surgery follow-up period for each surgery is listed in the "Fol-Up" column in the Professional Services Fee Schedule.

Services and Supplies Included in the Global Surgery Policy

The following services and supplies are included in the global surgery follow-up period and are considered bundled into the surgical fee:

- The operation itself.
- Preoperative visits, in or out of the hospital, beginning on the day before the surgery.
- Services by the primary surgeon, in or out of the hospital, during the postoperative period.
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; insertion, irrigation and removal of urinary catheters, cast room charges, routine peripheral IV lines, nasogastric and rectal tubes; and change and removal of tracheostomy tubes. Casting materials are not part of the global surgery policy and are paid separately.
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

How to Apply the Follow-Up Period

The follow-up period applies to **any provider** who participated in the surgical procedure. These providers include:

- Surgeon or physician who performs any component of the surgery (e.g., the pre, intra and/or postoperative care of the patient; identified by modifiers –56, -54 and –55)
- Assistant surgeon (identified by modifiers –80, -81 and –82)
- Two surgeons (identified by modifier –62)
- Team surgeons (identified by modifier –66)
- Anesthesiologists and CRNAs

The follow-up period always applies to the following CPT® codes, unless modifier -24, -25, -57 or -79 is appropriately used:

E/M Codes		Ophthalmological Codes
99211-99215	99301-99303	92012-92014
99218-99220	99311-99316	
99231-99239	99331-99333	
99261-99263	99347-99350	
99291-99292		

Professional inpatient services (CPT® codes 99211-99223) are only payable during the follow-up period if they are performed on an emergency basis (i.e., they are not payable for scheduled hospital admissions).

Codes that are considered bundled are **not payable** during the global surgery follow-up period.

PRE, INTRA, OR POSTOPERATIVE SERVICES

The department or Self-Insurer will allow separate payment when different physicians or providers perform the preoperative, intraoperative or postoperative components of the surgery. The appropriate modifiers (-54, -55 or -56) must be used. The percent of the maximum allowable fee for each component is listed in the Professional Services Fee Schedule.

If different providers perform different components of the surgery (pre, intra or postoperative care), the global surgery policy applies to each provider. For example, if the surgeon performing the operation transfers the patient to another physician for the postoperative care, the same global surgery policy, including the restrictions in the follow-up day period, applies to both physicians.

MINOR SURGICAL PROCEDURES

For minor surgical procedures, the department follows CMS's policy to not allow payment for an E/M office visit during the global period unless:

- A documented, unrelated service is furnished during the postoperative period and modifier –24 is used, or
- The practitioner who performs the procedure is seeing the patient for the first time, in which case an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier –25 must be used. Appropriate documentation must be made in the chart describing the E/M service.

CPT® code 99025, initial surgical evaluation, is considered bundled and is not separately payable. Modifier –57, decision for surgery, is not payable with minor surgeries. When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation is not paid in addition to the procedure.

Modifier –57 is payable with an E/M service only when the visit results in the initial decision to perform major surgery.

STANDARD MULTIPLE SURGERY POLICY

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

100% of the global fee for the procedure or procedure group with the highest value, according to the fee schedule.

50% of the global fee for the **second through fifth procedures** with the next highest values, according to the fee schedule.

Procedures in excess of five require submission of documentation and individual review to determine payment amount.

When different types of surgical procedures are performed on the same patient on the same day for accepted conditions, the payment policies will always be applied in the following sequence:

- Multiple endoscopy procedures for endoscopy procedures
- Other modifier policies
- Standard multiple surgery policy
- When the same surgical procedure is performed on multiple levels, each level must be billed as a separate line item. See the Bilateral Procedures Policy for additional instructions on billing bilateral procedures.

BILATERAL PROCEDURES POLICY

Bilateral surgeries should be billed as two line items. Modifier –50 should be applied to the second line item. When billing for bilateral surgeries, the two line items should be treated as one procedure. The second line item is paid at the lesser of the billed charge or 50% of the fee schedule maximum.

Check the Professional Services Fee Schedule to see if modifier –50 is valid with the procedure performed.

Example: Bilateral Procedure

Line Item	CPT® Code/Modifier	Maximum Payment (non-facility setting)	Bilateral Policy Applied	Allowed Amount
1	64721	$ 499.21		$ 499.21 (1)
2	64721-50	$ 499.21	$ 249.62 (2)	$ 249.62
Total Allowed Amount in Non-Facility Setting:				$ 748.83 (3)

(1) Allowed amount for the highest valued procedure is the fee schedule maximum.
(2) When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a modifier –50 is paid at 50% of the value paid for the first line item.
(3) Represents total allowable amount.

ENDOSCOPY PROCEDURES POLICY

For the purpose of these payment policies, the term, “endoscopy” will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

Payment is not allowed for an E/M office visit (CPT® codes 99201-99215) on the same day as a diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier –25 is used.

Endoscopy procedures are grouped into clinically related “families.” Each endoscopy family contains a “base” procedure that is generally defined as the diagnostic procedure (as opposed to a surgical procedure).

The base procedure for each code belonging to an endoscopy family is listed in the “Endo Base” column in the Professional Services Fee Schedule. Base procedures and their family members are also identified in **Appendix A**, “Endoscopy Families.”

When multiple endoscopy procedures belonging to the same family (related to the same base procedure) are billed, maximum payment is calculated as follows:

1. Maximum payment for the endoscopy procedure with the highest dollar value listed in the fee schedule is 100% of the fee schedule value.
2. For subsequent endoscopy procedures, maximum payment is calculated by subtracting the fee schedule maximum for the base procedure from the fee schedule maximum for the endoscopy family member.
3. When the fee schedule maximum for a family member is less than that of the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for this family member equal to $0.00 (see example 2).
4. No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an "endoscopic group." If more than one endoscopic group or other non-endoscopy procedure is billed for the same patient on the same day by the same provider, the standard multiple surgery policy will be applied to all procedures (see example 3).

Multiple endoscopies that are not related (e.g., each is a separate and unrelated procedure) are priced as follows:

1. 100% for each unrelated procedure, then
2. Apply the standard multiple surgery policy

Example 1: Two Endoscopy Procedures in the Same Family

Line Item	CPT® Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	29870	$ 535.16	$ 000.00 (2)	
1	29874	$ 705.28	$ 170.12 (4)	$ 170.12 (5)
2	29880	$ 858.18	$ 858.18 (3)	$ 858.18 (5)
			Total Allowed Amount in Non-Facility Setting:	$ 1028.30 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Payment is not allowed for a base code when a family member is billed.
(3) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
(4) Allowed amount for other procedures in the same endoscopy family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.
(5) Amount allowed under the endoscopy policy.
(6) Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy does not apply because only one family of endoscopic procedures was billed.

Example 2: Endoscopy Family Member With Fee Less than Base Procedure

Line Item	CPT® Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Allowed Amount
Base (1)	43235	$ 385.30		
1	43241	$ 196.44	$ 000.00 (3)	
2	43251	$ 274.92	$ 274.92 (2)	$ 274.92 (4)
			Total Allowed Amount in Non-Facility Setting:	$ 274.92 (5)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued procedure in the family is the fee schedule maximum.
(3) When the fee schedule maximum for a code in an endoscopy family is less than the fee schedule maximum for the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.
(4) Allowed amount under the endoscopy policy.
(5) Represents total allowed amount. Standard multiple surgery policy does not apply because only one endoscopic group was billed.

Example 3: Two Surgical Procedures Billed with an Endoscopic Group

Line Item	CPT® Code	Maximum Payment (non-facility setting)	Endoscopy Policy Applied	Standard Multiple Surgery Policy Applied
1	11402	$ 197.46		$ 98.73 (5)
2	11406	$ 310.87		$ 155.44 (5)
Base (1)	29830	$ 598.95		
3	29835	$ 666.80	$ 67.85 (3)	$ 67.85 (4)
4	29838	$ 789.32	$ 789.32 (2)	$ 789.32 (4)
Total Allowed Amount in Non-Facility Setting:				$ 1111.34 (6)

(1) Base code listed is for reference only (not included on bill form).
(2) Allowed amount for the highest valued arthroscopy procedure is the fee schedule maximum.
(3) Allowed amount for the second highest valued arthroscopy procedure in the family is calculated by subtracting the fee schedule maximum for the base code from the fee schedule maximum for the non-base code.
(4) Standard multiple surgery policy is applied, with the highest valued surgical procedure or procedure group being paid at 100%.
(5) Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
(6) Represents total allowed amount after applying all applicable global surgery policies.

MICROSURGERY

CPT® code 69990 is an "add-on" surgical code that indicates an operative microscope has been used. As an "add-on" code, it is not subject to multiple surgery rules.

CPT® code 69990 is not payable when:

- Using magnifying loupes or other corrected vision devices, or
- Use of the operative microscope is an inclusive component of the procedure, (i.e., the procedure description specifies that microsurgical techniques are used), or
- Another code describes the same procedure being done with an operative microscope. For example, CPT® code 69990 may not be billed with CPT® code 31535, operative laryngoscopy, because CPT® code 31536 describes the same procedure using an operating microscope. The table below contains a complete list of all such codes.

CPT® Codes Not Allowed with CPT® 69990

CPT®Code	CPT®Code	CPT®Code	CPT®Code
15756-15758	26551-26554	31540-31541	61548
15842	26556	31560-31561	63075-63078
19364	31520	31570-31571	64727
19368	31525-31526	43116	64820-64823
20955-20962	31530-31531	43496	65091-68850
20969-20973	31535-31536	49906	

SPINAL INJECTION POLICY

Injection procedures are divided into three categories:

1. Injection procedures that require fluoroscopy.
2. Injection procedures that may be done without fluoroscopy when performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. These procedures require fluoroscopy if they are not performed at a certified or accredited facility.
3. Injection procedures that do not require fluoroscopy.

Definition of Certified or Accredited Facility

The department defines a certified or accredited facility as a facility or office that has certification or accreditation from one of the following organizations:

1. Medicare (CMS - Centers for Medicare and Medicaid Services)
2. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
3. Accreditation Association for Ambulatory Health Care (AAAHC)
4. American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF)
5. American Osteopathic Association (AOA)
6. Commission on Accreditation of Rehabilitation Facilities (CARF)

Spinal Injection Procedures that Require Fluoroscopy

CPT® Code	Abbreviated CPT® Code Description	CPT® Fluoroscopy Codes(1),(2)
62268	Drain spinal cord cyst	76003, 76360, 76942
62269	Needle biopsy, spinal cord	76003, 76360, 76942
62281	Treat spinal cord lesion	76005, 72275
62282	Treat spinal cord canal	76005, 72275
62284	Injection for myelogram or CT scan	76005, 76360, 76942, 72240, 72255, 72265, 72270
62290	Inject for spine disk x-ray	72295
62291	Inject for spine disk x-ray	72285
62292	Injection for disk lesion	72295
62294	Injection into spinal artery	76003, 76005, 76360, 75705
62310	Inject spine c/t	76005, 72275
62311	Inject spine l/s (cd)	76005, 72275
62318	Inject spine w/cath, c/t	76005, 72275
62319	Inject spine w/cath l/s (cd)	76005, 72275
64470	Inject paravertebral c/t	76005
64472	Inject paravertebral c/t add-on	76005
64475	Inject paravertebral l/s	76005
64476	Inject paravertebral l/s add-on	76005
64479	Inject foramen epidural c/t	76005, 72275
64480	Inject foramen epidural add-on	76005, 72275
64483	Inject foramen epidural l/s	76005, 72275
64484	Inject foramen epidural add-on	76005, 72275

(1) One of the indicated fluoroscopy codes must be billed along with the underlying procedure code or the bill for the underlying procedure will be denied.

(2) Only one of the indicated fluoroscopy codes may be billed for each injection.

Spinal Injection Procedures that May Be Done Without Fluoroscopy

Interlaminar epidural steroid injections may be performed without fluoroscopy if performed at a certified or accredited facility by a physician with privileges to perform the procedure at that facility. The physician must decide whether to use fluoroscopy based on sound medical practice.

To be payable, these spinal injections must include a facility place of service code and documentation that the procedure was performed at a certified or accredited facility.

CPT® Code	Abbreviated CPT® Code Description
62310	Inject spine c/t
62311	Inject spine l/s (cd)
62318	Inject spine w/cath, c/t
62319	Inject spine w/cath l/s (cd)

Spinal Injection Procedures that Do Not Require Fluoroscopy

CPT® Code	Abbreviated CPT® Code Description
62270	Spinal fluid tap diagnostic
62272	Drain spinal fluid
62273	Treat epidural spine lesion

Payment Methods for Spinal Injection Procedures

Provider Type	Procedure Type	Payment Method
Physician or CRNA/ARNP	Injection	-26 Component of Professional Services Fee Schedule
	Radiology	-26 Component of Professional Services Fee Schedule
Radiology Facility	Injection	No Facility Payment
	Radiology	-TC Component of Professional Services Fee Schedule
Hospital(1)	Injection	APC or POAC
	Radiology(2)	APC or -TC Component of Professional Services Fee Schedule
ASC	Injection	ASC Fee Schedule
	Radiology	-TC Component of Professional Services Fee Schedule

(1) Payment method depends on a hospital's classification.
(2) Radiology codes may be packaged with the injection procedure.

REGISTERED NURSES AS SURGICAL ASSISTANTS

Licensed registered nurses may perform surgical assistant services if the registered nurse submits the following documents to the department or Self-Insurer along with a completed provider application.

1. A photocopy of her or his valid and current registered nurse license, and
2. A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is 90% of the allowed fee that would otherwise be paid to an assistant surgeon.

PROCEDURES PERFORMED IN A PHYSICIAN'S OFFICE

Modifier –SU denotes the use of facility and equipment while performing a procedure in a physician's office.

Modifier –SU is not covered and the department will not make a separate facility payment. Procedures performed in a physician's office are paid at nonfacility rates that include office expenses.

Physicians' offices must meet ASC requirements to qualify for separate facility payments. Refer to Chapter 296-23B WAC for information about the requirements.

MISCELLANEOUS

Angioscopy

Payment for angioscopies (CPT® code 35400) is limited to only one unit based on its complete code description encompassing multiple vessels. The work involved with varying numbers of vessels was incorporated in the RVUs.

Autologous Chondrocyte Implant

The department or Self-Insurer may cover autologous chondrocyte implant (ACI) when all of the guidelines outlined in Provider Bulletin 03-02, *Coverage Decisions*, are met. ACI requires prior authorization.

In addition to the clinical guidelines for the procedure, the surgeon must have received training through Genzyme Biosurgery and have performed or assisted with 5 ACI procedures or perform ACI under the direct supervision and control of a surgeon who has performed 5 or more ACI procedures.

If the procedure is authorized, the department will pay Genzyme Biosurgery directly for Carticel® (autologous cultured chondrocytes). For more information, go to http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

Bone Morphogenic Protein

The department may cover the use of bone morphogenic protein as an alternative to autograft in recalcitrant long bone nonunion where use of autograft is not feasible and alternative treatments have failed. It may also cover its use for spinal fusions in patients with degenerative disc disease at one level from L4-S1.

All of the criteria and guidelines outlined in Provider Bulletin 04-01, *Coverage Decisions, July 2003 to December 2003* must be met before the department will authorize the procedures. For more information, go to http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

In addition lumbar fusion guidelines must be met. Information about the guidelines can be found at http://www.LNI.wa.gov/ClaimsInsurance/Providers/TreatmentGuidelines/MedPub/default.asp.

Closure of Enterostomy

Closures of enterostomy (CPT® codes 44625 and 44626) are not payable with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy (CPT® code 44139). CPT® code 44139 will be denied if it is billed with CPT® code 44625 or 44626.

Meniscal Allograft Transplantation

The department or Self-Insurer may cover meniscal allograft transplantation when all of the guidelines outlined in Provider Bulletin 03-02, Coverage Decisions, are met. Meniscal allograft transplantation requires prior authorization.

In addition to the clinical guidelines for the procedure, the surgeon must have performed or assisted with 5 meniscal allograft transplants or perform the transplant under the direct supervision and control of a surgeon who has performed 5 or more transplants. For more information, go to http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

ANESTHESIA SERVICES

Anesthesia payment policies are established by the department with input from the RSC and the Anesthesia Technical Advisory Group (ATAG). The RSC is a standing committee with representatives from L&I, DSHS and HCA. The ATAG includes anesthesiologists, CRNAs and billing professionals.

NON-COVERED AND BUNDLED SERVICES

Anesthesia Assistant Services

The department does not cover anesthesia assistant services.

Non-Covered Procedures

Anesthesia is not payable for procedures that are not covered by the department. Refer to **Appendix D** for a list of non-covered procedures.

Patient Acuity

Patient acuity does not affect payment levels. Payment for qualifying circumstances (CPT® codes 99100, 99116, 99135 and 99140) is considered bundled and is not payable separately. CPT® physical status modifiers (-P1 to -P6) and CPT® five-digit modifiers are not accepted.

Anesthesia by Surgeon

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure. Services billed with modifier -47 (anesthesia by surgeon) are considered bundled and are not payable separately.

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

CRNA services are paid at a maximum of 90% of the allowed fee that would otherwise be paid to a physician.

Refer to WAC 296-23-240 for licensed nursing rules and 296-23-245 for licensed nursing billing instructions. For more detailed billing instructions, including examples of how to submit bills, refer to the department's HCFA-1500 billing instructions (publication F248-094-000).

CRNA services should not be reported on the same HCFA-1500 form used to report anesthesiologist services; this applies to solo CRNA services as well as team care.

MEDICAL DIRECTION OF ANESTHESIA (TEAM CARE)

The department follows CMS's policy for medical direction of anesthesia (team care).

Requirements for Medical Direction of Anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a pre-anesthetic examination and evaluation, and
- Prescribe the anesthesia plan, and
- Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, and
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions, and
- Monitor the course of anesthesia administration at frequent intervals, and
- Remain physically present and available for immediate diagnosis and treatment of emergencies, and
- Provide indicated post-anesthesia care.

In addition, physicians directing anesthesia:

- May direct no more than four anesthesia services concurrently, and
- May not perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

Documentation Requirements for Team Care

The physician must document in the patient's medical record that the medical direction requirements were met. The physician does not need to submit this documentation with the bill, but must make the documentation available to the insurer upon request.

Billing for Team Care

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate HCFA-1500 forms using their own provider account numbers.
- Anesthesiologists must use the appropriate modifier for medical direction or supervision (-QK or -QY).
- CRNAs should use modifier -QX.

Payment for Team Care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services.
  (Refer to Anesthesia Payment Calculation in the Anesthesia Services Paid with Base and Time Units section.)
- The maximum payment to the physician is 50% of the maximum payment for solo physician services.
- The maximum payment to the CRNA is 45% of the maximum payment for solo physician services (90% of the other 50% share).

ANESTHESIA SERVICES PAID WITH BASE AND TIME UNITS

Most anesthesia services are paid with base and time units. These services should be billed with CPT® anesthesia codes 00100 through 01999 and the appropriate anesthesia modifier.

Anesthesia Base Units

Most of the department's anesthesia base units are the same as the 2003 anesthesia base units adopted by CMS. The department diverges from the CMS base units for some procedure codes based on input from the ATAG. The anesthesia codes, base units and base sources are listed in the Professional Services Fee Schedule.

Anesthesia Time

Anesthesia time begins when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent).

Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant attendance (i.e., when the patient can be safely placed under postoperative supervision). Anesthesia must be billed in one-minute time units.

List only the time in minutes on your bill. Do not include the base units. The appropriate base units will be automatically added by the department's payment system when the bill is processed.

Anesthesia Modifiers

Anesthesiologists and CRNAs should use the modifiers in this section when billing for anesthesia services paid with base and time units. With the exception of modifier –99, these modifiers are not valid for anesthesia services paid by the RBRVS method.

Services billed with CPT® five-digit modifiers and physical status modifiers (P1 through P6) will not be paid. Refer to a current CPT® or HCPCS book for complete modifier descriptions and instructions.

CPT® Modifier

For Use By	Modifier	Brief Description	Notes
Anesthesiologists and CRNAs	-99	Multiple modifiers	Use this modifier when five or more modifiers are required. Enter –99 in the modifier column on the bill. List individual descriptive modifiers elsewhere on the billing document.

HCPCS Modifiers

For Use By	Modifier	Brief Description	Notes
Anesthesiologists	-AA	Anesthesia services performed personally by anesthesiologist	
	-QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individual	Payment based on policies for team services.
	- QY	Medical direction of one CRNA for a single anesthesia procedure	Payment based on policies for team services.
CRNAs*	-QX	CRNA service: with medical direction by a physician	Payment based on policies for team services.
	-QZ	CRNA service: without medical direction by a physician	Maximum payment is 90% of the maximum allowed for physician services.

* Bills from CRNAs that do not contain a modifier are paid based on payment policies for team services.

Anesthesia Payment Calculation

The maximum payment for anesthesia services paid with base and time units is calculated using the base value for the procedure, the time the anesthesia service is administered and the department's anesthesia conversion factor.

The anesthesia conversion factor is published in WAC 296-20-135. For services provided on or after July 1, 2004, the anesthesia conversion factor is $42.15 per 15 minutes ($2.81 per minute). Providers are paid the lesser of their charged amount or the department's maximum allowed amount.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by fifteen.
2. Add the value from step 1 to the total number of whole minutes.
3. Multiply the result from step 2 by $2.81.

The maximum payment for services provided by a CRNA is 90% of the maximum payment for a physician.

Example: CPT® code 01382 (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

1. Base units x 15 = 3 x 15 = 45 base units,
2. 45 base units + 60 time units (minutes) = 105 base and time units,
3. Maximum payment for physicians = 105 x $ 2.81 = $ 295.05

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes should be billed with a primary anesthesia code. There are three anesthesia add-on codes in the 2003 CPT® book: 01953, 01968 and 01969. CPT® add-on code 01953 should be billed with primary code 01952. CPT® add-on codes 01968 and 01969 should be billed with primary code 01967.

Anesthesia add-on codes 01968 and 01969 should be billed in the same manner as other anesthesia codes paid with base and time units. Providers should report the total time for the add-on procedure (in minutes) in the "Units" column (Field 24G) of the HCFA-1500 form.

Anesthesia for Burn Excisions or Debridement

The anesthesia add-on code for burn excision or debridement, CPT® code 01953, must be billed according to the instructions in the following table.

Total Body Surface Area	Primary Code	Units of Add-On Code 01953
Less than 1 percent	01951	None
1 - 9 percent	01952	None
Up to 18 percent	01952	1
Up to 27 percent	01952	2
Up to 36 percent	01952	3
Up to 45 percent	01952	4
Up to 54 percent	01952	5
Up to 63 percent	01952	6
Up to 72 percent	01952	7
Up to 81 percent	01952	8
Up to 90 percent	01952	9
Up to 99 percent	01952	10

ANESTHESIA SERVICES PAID BY THE RBRVS METHOD

Some services commonly performed by anesthesiologists and CRNAs are not paid with anesthesia base and time units. These services include anesthesia CPT® code 01996, evaluation and management services, most pain management services and other selected services. These services paid by the RBRVS payment method and are listed in **Appendix F**.

Modifiers

Anesthesia modifiers -AA, -QK, -QX, -QY and -QZ are not valid for services paid by the RBRVS method.

Refer to a current CPT® or HCPCS book for a complete list of modifiers and descriptions. Refer to **Appendix E** for a list of modifiers that affect payment.

Maximum Payment

Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule.

When billing for services paid with the RBRVS method, enter the total number of times the procedure is performed, not the total minutes, in the "Units" column (Field 24G on the HCFA-1500 bill form).

E/M Services Payable with Pain Management Procedures

An E/M service is payable on the same day as a pain management procedure only when:

- It is the patient's initial visit to the practitioner who is performing the procedure, or
- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service.

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action. The use of E/M codes on days after the procedure is performed is subject to the global surgery policy (refer to the Surgery Services section).

Injection Code Treatment Limits

Details regarding treatment guidelines and limits for the following kinds of injections can also be found in WAC 296-20-03001. Refer to Medication Administration in the Other Medicine Services section for information on billing for medications.

Injection	Treatment Limit
Epidural and caudal injections of substances other than anesthetic or contrast solution	**Maximum of six** injections per acute episode are allowed.
Facet injections	**Maximum of four** injection procedures per patient are allowed.
Intramuscular and trigger point injections of steroids and other non-scheduled medications and trigger point dry needling(1)	**Maximum of six** injections per patient are allowed.

(1) Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services (WAC 296-20-03002). Dry needling of trigger points should be billed using trigger point injection codes 20552 or 20553. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

RADIOLOGY

X-RAY SERVICES

Repeat X-Rays

No payment will be made for excessive or unnecessary x-rays. Repeat or serial x-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s) when need is supported by documented changes in objective findings or subjective complaints.

Number of Views

There is no code that is specific for additional views for radiology services. Therefore, the number of views of x-rays that may be paid is determined by the CPT® description for the particular service.

For example, the following CPT® codes for radiologic exams of the spine are payable as outlined below:

CPT® Code	Payable
72020	Once for a single view
72040	Once for two to three views
72050	Once for four or more views
72052	Once, regardless of the number of views it takes to complete the series

-RT and –LT Modifiers

HCPCS modifiers –RT (right side) and –LT (left side) do not affect payment, but may be used with CPT® radiology codes 70010-79999 to identify duplicate procedures performed on opposite sides of the body.

Portable X-Rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving extremities, pelvis, vertebral column or skull
- Chest or abdominal films that do not involve the use of contrast media
- Diagnostic mammograms

HCPCS codes for transportation of portable x-ray equipment R0070 (one patient) or R0075 (multiple patients) may be paid in addition to the appropriate radiology code(s).

Custody

X-rays must be retained for ten years. See WACs 296-20-121 and 296-23-140(1).

CONSULTATION SERVICES

CPT® code 76140, x-ray consultation, is not covered. For radiology codes where a consultation service is performed, providers must bill the specific x-ray code with the modifier –26. For example, if a consultation is made on a chest x-ray, single view, frontal, the provider would bill CPT® code 71010-26.

Separate payment will not be made for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the x-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed.

Payment for a radiological consultation will be made at the established professional component (modifier –26) rate for each specific radiology service. A written report of the radiology consultation is required.

CONTRAST MATERIAL

Separate payment will not be made for contrast material unless a patient requires low osmolar contrast media (LOCM). LOCM may be used in intrathecal, intravenous and intra-arterial injections for patients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting,
- A history of asthma or allergy,
- Significant cardiac dysfunction including recent imminent cardiac decompensation, arrhythmias, unstable angina pectoris, recent myocardial infarction and pulmonary hypertension,
- Generalized severe debilitation, or
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS code, A4644, A4645 or A4646. The brand name of the LOCM and the dosage must be documented in the patient's chart. HCPCS codes and payment levels are listed in the Professional Services Fee Schedule.

HCPCS codes A4644, A4645 and A4646 are paid at a flat rate based on the AWP per ml. Bill one unit per ml. A9525, Low/iso-osmolar contrast mat, is not a valid code for LOCM.

NUCLEAR MEDICINE

The standard multiple surgery policies apply to the following radiology codes for nuclear medicine services.

CPT® Code	Abbreviated Description
78306	Bone imaging, whole body
78320	Bone imaging (3D)
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess

The multiple procedures reduction will be applied when these codes are billed:

- With other codes that are subject to the standard multiple surgery policy, and
- For the same patient, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice.

Refer to the Surgery Services section for more information about the standard multiple surgery payment policies.

PHYSICAL MEDICINE

GENERAL INFORMATION

Units of Service

Supervised modalities and therapeutic procedures that do not list a specific time increment in their description are limited to one unit per day.

Non-Covered and Bundled Codes

The following physical medicine codes are not covered:

Code	Abbreviated Description
CPT® 97005	Athletic train eval
CPT® 97006	Athletic train reeval
CPT® 97545(1)	Work hardening
CPT® 97546(1)	Work hardening add-on
CPT® 97033	Electric current therapy
CPT® 97781	Acupuncture w/stimul

(1) Work hardening services are paid with local codes. See Work Hardening and Work Conditioning later in this section.

The following are examples of bundled items or services:

- CPT® code 97010, application of hot or cold packs
- Ice packs, ice caps and collars
- Electrodes and gel
- Activity supplies used in work hardening, such as leather and wood
- Exercise balls
- Thera-taping
- Wound dressing materials used during an office visit and/or physical therapy treatment

Refer to the appendices for complete lists of non-covered and bundled codes.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists.

1045M Performance-based physical capacities evaluation with report and summary of capacities ..... $ 622.33

PHYSICAL MEDICINE AND REHABILITATION (PHYSIATRY)

Medical or Osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may be paid for CPT® codes 97001 through 97799. CPT® code 64550, apply neurostimulator (TENS), is payable only once per claim.

NON-BOARD CERTIFIED/QUALIFIED PHYSICAL MEDICINE PROVIDERS

Special payment policies apply for attending doctors who are not board qualified or certified in physical medicine and rehabilitation:

- Attending doctors who are not board qualified or certified in physical medicine and rehabilitation will not be paid for CPT® codes 97001-97799. They may perform physical medicine modalities and procedures described in CPT® codes 97001-97750 if their scope of practice and training permit it, but must bill local code 1044M for these services.

- Local code 1044M is limited to six visits per claim, except when the attending doctor practices in a remote location where no licensed, registered physical therapist is available.
- After six visits, the patient must be referred to a licensed, registered physical therapist or physiatrist for such treatment. Refer to WAC 296-21-290 for more information.

1044M Physical medicine modality(ies) and/or procedure(s) by attending doctor who is not board qualified or certified in physical medicine and rehabilitation. Limited to first six visits except when doctor practices in a remote area. ..... $ 37.97

PHYSICAL AND OCCUPATIONAL THERAPY

Physical and occupational therapy services must be ordered by the worker's attending doctor.

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant serving under the direct supervision of a registered physical therapist (see WAC 296-23-220).

Occupational therapy services must be provided by a licensed occupational therapist or occupational therapist assistant serving under the direction of a licensed occupational therapist (see WAC 296-23-230).

Billing Codes

Physical and occupational therapists must use the appropriate physical medicine CPT® codes 97001-97799, with the exceptions noted later in this section. In addition, physical and occupational therapists must bill the appropriate covered HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to the Supplies, Materials and Bundled Services section.

If more than one patient is treated at the same time in a group setting, use CPT® code 97150, group therapeutic procedures.

Daily Maximum for Services

The daily maximum allowable fee for physical and occupational therapy services (see WAC 296-23-220 and WAC 296-23-230)…..... $104.12

The daily maximum applies to CPT® codes 64550 and 97001-97799 when performed for the same patient for the same date of service. If both physical and occupational therapy services are provided on the same day, the daily maximum applies once for each provider type.

The daily maximum allowable fee does not apply to performance based physical capacities examinations (PCEs), work hardening services, work evaluations or job/pre-job accommodation consultation services.

Physical and Occupational Therapy Evaluations

Physical and occupational therapy evaluations must be billed with CPT® codes 97001 through 97004 according to the table below.

Provider	Initial Evaluation	Reevaluation
Physician or Physical Therapist	CPT® 97001	CPT® 97002
Physician or Occupational Therapist	CPT® 97003	CPT® 97004

CPT® codes 97001 and 97003 are used to report the initial evaluation before the plan of care is established by the physician or therapist. The purpose of the initial evaluation is to evaluate the patient's condition and establish a plan of care.

CPT® codes 97002 and 97004 are used to report the reevaluation of a patient who has been under a plan of care established by the physician or therapist. This evaluation is for the purpose of re-evaluating the patient's condition and revising the plan of care under which the

patient is being treated. There is no limit as to how frequently CPT® codes 97002 and 97004 can be billed.

Wound Debridement

Therapists may not bill the surgical CPT® codes for wound debridement. Therapists must bill CPT® 97601 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (e.g., whirlpool).

Wound dressings and supplies used in the office are bundled and are not separately payable. Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier -1S. See the Supplies, Materials and Bundled Services section for more information.

MASSAGE THERAPY

Massage therapists must bill CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The department will not pay massage therapists for additional codes.

Massage therapists must bill their usual and customary fee and designate the duration of the massage therapy treatment.

Massage is a physical medicine service and is subject to the daily maximum allowable amount of ..... $104.12.

The application of hot or cold packs (CPT® code 97010), anti-friction devices and lubricants (e.g., oils, lotions, emollients, etc.) are bundled into the massage therapy service and are not payable separately. Refer to WAC 296-23-250 for additional information.

Massage therapy services must be billed in 15-minute time increments. Bill one unit of CPT® code 97124 for each 15 minutes of massage therapy.

PHYSICAL MEDICINE CPT® CODES BILLING GUIDANCE

The following provides guidance regarding the use of CPT® codes 97032-97036, 97110-97124, 97140, 97504-97542 and 97703-97755.

Timed Codes

Several CPT® codes used for therapy modalities, procedures and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any calendar day** using CPT® codes and the appropriate number of units of service. For any single CPT® code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes to less than 38 minutes, then 2 units should be billed. Time intervals for larger numbers of units are as follows:

Units Reported on the Claim	Number Minutes
3 units	> 38 minutes to < 53 minutes
4 units	> 53 minutes to < 68 minutes
5 units	> 68 minutes to < 83 minutes
6 units	> 83 minutes to < 98 minutes
7 units	> 98 minutes to < 113 minutes
8 units	> 113 minutes to < 128 minutes

If more than one CPT® code is billed during a calendar day, then the total number of units that can be billed is constrained by the total treatment time.

- Example 1: If 24 minutes of CPT® code 97112 and 23 minutes of CPT® code 97110 were furnished, then the total treatment time was 47 minutes; so only 3 units can be billed for the treatment. The correct coding is 2 units of CPT® code 97112 and one unit of CPT® code 97110, assigning more units to the service that took the most time.
- Example 2: If a therapist delivers 5 minutes of CPT® code 97035 (ultrasound), 6 minutes of CPT® code 97140 (manual techniques), and 10 minutes of CPT® code 97110 (therapeutic exercise), then the total minutes are 21 and only one unit can be paid. Bill one unit of CPT® code 97110 (the service with the longest time time) and the clinical record will serve as documentation that the other two services were also performed.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

In the same 15-minute (or other) time period, a therapist cannot bill any of the following pairs of CPT® codes for outpatient therapy services provided to the same, or to different patients. Examples include:

- Any two CPT® codes for “therapeutic procedures” requiring direct one-on-one patient contact (CPT® codes 97110-97542)
- Any two CPT® codes for modalities requiring “constant attendance” and direct one-on-one patient contact (CPT® codes 97032-97039)
- Any two CPT® codes requiring either constant attendance or direct one-on-one patient contact—as described above—(CPT® codes 97032-97542). For example: any CPT® codes for a therapeutic procedure (e.g., CPT® code 97116-gait training) with any attended modality CPT® code (e.g., CPT® code 97035-ultrasound)
- Any CPT® code for therapeutic procedures requiring direct one-on-one patient contact (CPT® codes 97110-97542) with the group therapy CPT® code 97150 requiring constant

attendance. For example: group therapy (CPT® code 97150) with neuromuscular reeducation (CPT® code 97112)

- Any CPT® code for modalities requiring constant attendance (CPT® codes 97032-97039) with the group therapy (CPT® code 97150). For example: group therapy (CPT® code 97150) with ultrasound (CPT® code 97035)
- Any untimed evaluation or reevaluation code (CPT® codes 97001-97004) with any other timed or untimed CPT® codes, including constant attendance modalities (CPT® codes 97032-97039), therapeutic procedures (CPT® codes 97110-97542) and group therapy (CPT® code 97150)

Determining What Time Counts Towards 15-Minute Timed Codes

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. In other words, the time counted as "intra-service care" begins when the therapist or physician (or an assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (e.g., on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated. For example, if gait training in a patient with a recent stroke requires both a therapist and an assistant, or even two therapists, to manage in the parallel bars, each 15 minutes the patient is being treated can count as only one unit of CPT® code 97116. The time the patient spends not being treated because of the need for toileting or resting should not be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin is not considered treatment time.

Regardless of the number of units billed, the daily maximum for services will not be exceeded.

WORK HARDENING AND WORK CONDITIONING

Work Hardening

Work hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular and psychosocial functioning of the worker.

Work hardening programs require prior approval by the worker's attending physician and prior authorization by the claim manager.

Only department approved work hardening providers will be paid for work hardening services.

More information about the department's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program and other work hardening program standards is available on the department's web site at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ReturnToWork/WorkHard/default.asp This information is also available by calling the Provider Hotline at 1-800-848-0811 or the work hardening program reviewer at (360) 902-5622.

Work hardening CPT® codes 97545 and 97546 are not covered. Work hardening services are paid with local codes 1000M-1018M. Refer to the Local Codes section of the Professional Services Fee Schedule for code descriptions and maximum fees.

Work Conditioning

The department does not recognize work conditioning as a special program. Work conditioning is paid according to the rules for outpatient physical and occupational therapy (see WAC 296-23-220 and WAC 296-23-230).

OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT) using CPT® codes 98925 through 98929. CPT® code 97140, manual therapy, is not covered for osteopathic physicians.

For OMT services (CPT® codes 98925-98929) body regions are defined as: head, cervical, thoracic, lumbar, sacral, pelvic, rib cage, abdomen and viscera regions; lower and upper extremities.

These codes ascend in value to accommodate the additional body regions involved. Therefore, only one code is payable per treatment. For example, if three body regions were manipulated, one unit of CPT® code 98926 would be payable.

OMT includes pre- and post-service work (e.g., cursory history and palpatory examination). E/M office visit services are not to be routinely billed in conjunction with OMT. E/M office visit service (CPT® codes 99201-99215) may be billed in conjunction with OMT **only when all of the following conditions are met:**

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient's record supporting the level of E/M billed, and
- The E/M service is billed using the -25 modifier.

E/M codes billed on the same day as OMT without the -25 modifier will not be paid.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

The department or Self-Insurer may reduce payment or process recoupments when E/M services are not documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

ELECTRICAL STIMULATORS

Electrical Stimulators Used in the Office Setting

Providers using stimulators in the office setting may bill professional services for application of stimulators with the CPT® physical medicine codes when such application is within the provider's scope of practice.

Devices and Supplies for Home Use or Surgical Implantation

See the Transcutaneous Electrical Nerve Stimulators (TENS) section for policies pertaining to TENS units and supplies. Coverage policies for other electrical stimulators and supplies are described below.

Electrical Stimulator Devices for Home Use or Surgical Implantation

HCPCS Code	Brief Description	Coverage Status
E0744	Neuromuscular stim for scoli	Not covered
E0745	Neuromuscular stim for shock	Covered for muscle denervation only. Prior authorization is required.
E0747	Elec Osteo stim not spine	Prior authorization is required.
E0748	Elec Osteogen stim spinal	Not covered
E0749	Elec Osteogen stim, implanted	Authorization subject to utilization review.
E0755	Electronic salivary reflex s	Not covered
E0760	Osteogen ultrasound, stimltor	Covered for appendicular skeleton only (not the spine). Prior authorization is required.

Electrical Stimulator Supplies for Home Use

HCPCS Code	Brief Description	Coverage Status
A4365	Adhesive remover wipes	Payable for home use only Bundled for physician office use
A4455	Adhesive remover per ounce	
A4556	Electrodes, pair	
A4557	Lead wires, pair	
A4558	Conductive paste or gel	
A5119	Skin barrier wipes box pr 50	
A6250	Skin seal protect moisturizr	
E0731	Conductive garment for TENS	Not covered
E0740	Incontinence treatment system	Not covered

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

PRESCRIBING TENS

TENS units may be prescribed by licensed medical, osteopathic, naturopathic and podiatric physicians and dental surgeons. Providers, both in and out-of state, who prescribe or dispense TENS units for State Fund injured workers must use the department's contracted vendor, Performance Modalities, Inc. (PMI).

DISPENSING TENS

Providers may maintain an inventory of some or all of the TENS units maintained by PMI or may order a TENS unit from PMI by calling 1-800-999-TENS (1-800-999-8367).

Providers who maintain an inventory of TENS units must notify PMI when they have dispensed a unit and PMI will replenish the inventory.

Providers may prescribe and dispense the following TENS units:

MANUFACTURER	TENS UNIT
American Imex	Interspec-IF(1)
American Imex	MicroCare II
American Imex	Premier AP
Electromedical Products	Alpha-Stim 100
Empi	Dynex V
Empi	Eclipse +
Empi	Epix VT
Empi	Epix XL
Sparta	Spectrum Max-SD

(1) This unit is classified by the FDA as a true interferential current stimulator. Only the interferential units listed in the PMI contract with the department are eligible for rental and purchase on an at-home basis. See Provider Update 03-01, *Transcutaneous Electrical Nerve Stimulation (TENS) Program* and Provider Bulletin 01-11, *Transcutaneous Electrical Nerve Stimulation (TENS).* Interferential units must be obtained from PMI.

TENS Instruction

The department allows the initial TENS application and training by a physical therapist or other qualified provider only once per claim. This service must be billed with CPT® code 64550.

Trial Evaluation Period

A provider may dispense a TENS unit to an injured worker for a free trial evaluation period. Prior authorization is not required for the trial evaluation.

The trial evaluation period begins when the TENS unit is dispensed and may last up to 30 days. During the trial evaluation period, the provider and the injured worker assess whether the TENS treatment is working and if rental of the unit is medically necessary.

RENTAL AND PURCHASE OF TENS

TENS rental or purchase requires prior authorization by the insurer.

Rental Period

The department requires a 30-day trial evaluation period before TENS rental will be considered.

If the TENS unit is beneficial during the trial evaluation period, the prescribing provider may request authorization for a four-month rental period. If authorized, the four-month authorization is dated from the day the TENS unit was initially dispensed for the trial evaluation.

Providers may request authorization for rental of a TENS unit by contacting PMI at 1-800-999-TENS (1-800-999-8367).

Purchase

The department requires a four-month rental period before TENS purchase will be considered.

After a TENS unit has been rented for three months, PMI will send a TENS Purchase Recommendation form to the prescribing provider.

At the end of the four-month rental period, the prescribing provider must decide whether or not to pursue purchasing a TENS unit for the injured worker.

If the prescribing provider does not want to purchase the TENS unit, the prescribing provider must check box 12 on the TENS Purchase Recommendation form, sign and return it to PMI.

If the prescribing provider decides to pursue purchasing the TENS unit for the worker, the prescribing provider must submit the completed TENS Purchase Recommendation form to PMI. PMI will submit the TENS purchase request to the department for consideration and will notify the provider and the injured worker of the department's authorization decision.

Second Purchase Review

If the TENS unit purchase request is denied and the prescribing provider and injured worker disagree with the department's decision, the provider may submit a written request for a second purchase review.

The second purchase review must be submitted to PMI within 30 days of notice of TENS purchase denial and must include additional objective information supporting both the injured worker's functional improvement and the effectiveness of TENS therapy.

PMI will submit the second purchase request to the department for consideration and will notify the provider and the injured worker of the department's authorization decision.

TENS Supplies

The department will pay for medically necessary supplies and batteries for the life of the TENS unit if the department has authorized the injured worker's use of the TENS unit for an accepted condition. All supplies and batteries must be obtained from PMI.

TENS Unit Repair and Replacement

TENS units dispensed on or after January 1, 2003, have a five-year warranty. TENS units dispensed prior to that date may or may not still be under warranty. Regardless of warranty status, TENS unit repair is a covered service as long as the damage to the TENS unit has not been caused by injured worker abuse, neglect or misuse. The department and PMI, at their discretion, will decide when or if to repair a TENS unit or replace it with a TENS unit comparable to the original unit. In cases where damage to the TENS unit is due to injured worker abuse, neglect or misuse, TENS unit repair or replacement is the responsibility of the injured worker. Replacement of a lost or stolen TENS unit is also the responsibility of the injured worker.

TENS Billing Codes

The department's contracted vendor and providers treating Self-Insured workers must use the appropriate HCPCS codes to bill for TENS units and supplies.

Sales tax and delivery charges are not separately payable and must be included in the total charge for the TENS unit and supplies.

HCPCS Code	Brief Description	Coverage Status
A4595	TENS Supp 2 lead per month	For State Fund claims: Payable to the department's contracted TENS vendor. For Self-Insured claims: Payable to DME suppliers.
A4630	Repl batt TENS own by pt	
E0730	TENS, four lead	

CHIROPRACTIC SERVICES

Chiropractic physicians must use the codes listed in this section to bill for services. In addition, chiropractic physicians must use the appropriate CPT® codes for radiology, office visit and case management services and HCPCS codes for miscellaneous materials and supplies.

Evaluation and Management

Chiropractic physicians may bill the first four levels of new and established patient office visit codes (CPT® 99201-99204 and 99211-99214). The department uses the CPT® definitions for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

The following payment policies apply when chiropractic physicians use E/M office visit codes:

- A new patient E/M office visit code is payable only once for the initial visit.
- An established patient E/M office visit code is not payable on the same day as a new patient E/M office visit code.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 is not payable with E/M codes for chiropractic services.
- Established patient E/M codes are not payable in addition to L&I chiropractic care visit codes for follow-up visits.
- Refer to the Chiropractic Care Visits section for policies about the use of E/M office visit codes with chiropractic care visit codes.

Chiropractic Care Visits

Chiropractic care visits are defined as office or other outpatient visits involving subjective and objective assessment of patient status, management and treatment. The levels of treatment are based on clinical complexity (similar to established patient evaluation and management services). Extremities are considered as one of the body regions and are not billed separately.

CPT® codes for chiropractic manipulative treatment (CPT® 98940-98943) are not covered. The department has developed the following clinical complexity based local codes for chiropractic care visits.

2050A	Level 1: Chiropractic Care Visit (straightforward complexity)	$ 36.33
2051A	Level 2: Chiropractic Care Visit (low complexity)	$ 46.53
2052A	Level 3: Chiropractic Care Visit (moderate complexity)	$ 56.68

The following payment policies apply to the use of chiropractic care visit codes:

- Only **one** chiropractic care visit code is payable per day.
- Office visits in excess of 20 visits or 60 days require prior authorization.
- Modifier -22 will be individually reviewed when billed with chiropractic care visit local codes (2050A-2052A). A report is required detailing the nature of the unusual service and the reason it was required. Payment will vary based on findings of the review. No payment will be made when this modifier is used for non-covered or bundled services (for example: application of hot or cold packs).
- See information below for the use of chiropractic codes with E/M office visit codes.

Use of Chiropractic Care Visit Codes with E/M Office Visit Codes

Chiropractic care visit codes (local codes 2050A-2052A) are payable in addition to E/M office visit codes (CPT® 99201-99204 and 99211-99214) **only when all of the following conditions are met:**

- The E/M service is for the initial visit for a new claim, and
- The E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included in the chiropractic care visit, and
- Modifier -25 is added to the new patient E/M code, and
- Supporting documentation describing the service(s) provided is in the patient's record.

When a patient requires reevaluation for an existing claim, either an established patient E/M code (CPT® codes 99211-99214) or a chiropractic care local code (2050A-2052A) is payable. Payment will not be made for both. Modifier -25 is not applicable in this situation.

Selecting the Level of Chiropractic Care Visit Code

The following table outlines the treatment requirements, presenting problems and face-to-face patient time involved in the three levels of chiropractic care visits.

Clinical decision making complexity is the primary component in selecting the level of chiropractic care visit. The department defines clinical decision making complexity according to the definitions for medical decision making complexity in the *Evaluation and Management Services Guidelines* section of the CPT® book.

	Selecting the Level of Chiropractic Care Visit		
	Primary Component	**Other Components**	
	Clinical decision making is typically	**Typical number of body regions(1) manipulated**	**Typical face-to-face time with patient and/or family**
Level 1 (2050A)	Straightforward	Up to 2	Up to 10-15 minutes
Level 2 (2051A)	Low complexity	Up to 3 or 4	Up to 15-20 minutes
Level 3 (2052A)	Moderate complexity	Up to 5 or more	Up to 25-30 minutes

(1) Body regions for chiropractic services are defined as:

- Cervical (includes atlanto-occipital joint)
- Thoracic (includes costovertebral and costotransverse joints)
- Lumbar
- Sacral
- Pelvic (includes sacro-iliac joint)
- Extraspinal: Any and all extraspinal manipulations are considered to be one region. Extraspinal manipulations include head (including temporomandibular joint, excluding atlanto-occipital), lower extremities, upper extremities and rib cage (excluding costotransverse and costovertebral joints).

Chiropractic Care Visit Examples

The following examples of chiropractic care visits are for illustrative purposes only. They are not intended to be clinically prescriptive.

EXAMPLES	
Level 1 **Chiropractic Care Visit** (straightforward complexity)	26-year-old male presents with mild low back pain of several days duration. Patient receives manipulation/adjustment of the lumbar region.
Level 2 **Chiropractic Care Visit** (low complexity)	55-year-old male presents with complaints of neck pain, midback and lower back pain. Patient receives 5 minutes of myofascial release prior to being adjusted. The cervical, thoracic and lumbar regions are adjusted.
Level 3 **Chiropractic Care Visit** (moderate complexity)	38-year-old female presents with headache, right anterior rib pain, low back pain with pain at the sacrococcygeal junction, as well as pain in the sacroiliac regions and right sided foot drop. Patient receives 10 minutes of moist heat application, 10 minutes of myofascial work, and manipulation/adjustment to the cervical and atlanto-occipital, thoracic, anterior rib area, lumbar, sacroiliac and sacrococcygeal regions.

Complementary and Preparatory Services

Chiropractic physicians are not separately paid for patient education or complementary and preparatory services. The department defines complementary and preparatory services as interventions that are used to prepare a body region for or facilitate a response to a chiropractic manipulation/adjustment. The application of heat or cold is considered a complementary and preparatory service.

For example: routine patient counseling regarding lifestyle, diet, self-care and activities of daily living, thermal modalities or some soft tissue work, exercise instruction involving a provision of a sheet of home exercises and a description in the course of a routine office visit.

Physical Medicine Treatment

CPT® physical medicine codes 97001-97799 are not payable to chiropractic physicians. Refer to Non-Board Certified/Qualified Physical Medicine Providers for more information.

Case Management

Refer to Case Management Services in the Evaluation and Management section for information on billing for case management services. These codes may be paid in addition to other services performed on the same day.

Consultations

Approved chiropractic consultants may bill the first four levels of CPT® office consultation codes (99241-99244). The department periodically publishes a policy on consultation referrals. This also includes a list of approved chiropractic consultants. To obtain the most recent bulletin, call the department's Provider Hotline at 1-800-848-0811 or refer to the Provider Bulletin website at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp

Chiropractic Independent Medical Exams

Chiropractic physicians must be on the Approved Examiners List to perform independent medical exams (IMEs). To be considered for placement on the Approved Examiners List, a chiropractic physician must have all of the following:

- Two years experience as a chiropractic consultant on the department's approved consultant list, and

- Successfully completed the department's disability rating course for Washington State, and
- Attended the department's Chiropractic Consultant Seminar during the previous 24 months, and
- Submitted the written examination required for certification.

For more information, refer to the *Medical Examiners' Handbook* (publication F252-001-000). See http://www.LNI.wa.gov/ClaimsInsurance/Providers/IME/. Chiropractic physicians performing impairment ratings on their own patients or upon referral should refer to the *Medical Examiners' Handbook* and Impairment Rating by Attending Doctors/Consultants later in this section.

Supplies

See the Supplies, Materials, and Bundled Services section for information about billing for supplies.

Radiology Services

Chiropractic physicians must bill diagnostic x-ray services using CPT® radiology codes and the policies described in the Radiology Services section. If needed, x-rays immediately prior to and immediately following the initial chiropractic adjustment may be allowed without prior authorization. X-rays subsequent to the initial study require prior authorization.

Only chiropractic physicians who are on the department's list of approved radiological consultants may bill for x-ray consultation services. To qualify, a chiropractic physician must be a Diplomate of the American Chiropractic Board of Radiology and must be approved by the department.

PSYCHIATRIC SERVICES

The psychiatric services policies in this section apply only to workers covered by the State Fund and Self-Insured employer workers (see WAC 296-21-270 and Provider Bulletin 03-03). For information on psychiatric policies applicable to the Crime Victims Compensation Program, refer to the department's booklet *Mental Health Treatment Rules and Fees* (F800-090-000) and Chapter 296-31 WAC.

PSYCHIATRIC CONDITIONS

Treatment may be authorized for psychiatric conditions caused or aggravated by an industrial condition. Treatment may also be temporarily authorized for unrelated psychiatric conditions that are retarding recovery of an allowed industrial condition. **However, unrelated conditions are NOT the responsibility of the department.** The department will stop payment for temporary treatment of unrelated conditions when:

- The allowed industrial condition is resolved or
- The allowed industrial condition is no longer delayed from recovery by the unrelated psychiatric condition(s).

Psychiatric treatment must be provided in an "intensive" manner, which the department defines as at least 10-12 treatments in a 90-day authorization period. Prior authorization is required for **both** an initial psychiatric evaluation and for continued treatment.

PROVIDERS OF PSYCHIATRIC SERVICES

Authorized psychiatric services **must** be performed by either a psychiatrist (MD or DO) or a licensed psychologist (PhD), (see WAC 296-21-270). Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service. Each provider must obtain his or her own L&I provider account number for billing and payment purposes.

The department does not cover psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master's level counselors, even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. Staff supervised by a psychiatrist or licensed clinical psychologist may administer psychological testing; however, the psychiatrist or licensed clinical psychologist must interpret the testing and prepare the reports.

PSYCHIATRISTS AS ATTENDING PHYSICIANS

A psychiatrist can only be an injured worker's attending physician when the department has accepted a psychiatric condition and it is the **only** condition being treated. A psychiatrist may also rate psychiatric permanent partial disability. Psychologists cannot be the attending physician and may not certify time loss or rate Permanent Partial Disability under department rules (see WAC 296-20-210).

PSYCHIATRIC TREATMENT PLANS

The psychiatrist or psychologist must submit a goal-directed treatment plan and reports that contain a summary of subjective complaints, objective observations, assessment toward meeting measurable goals, an updated intensive goal-directed treatment plan and include the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV or current edition) axis format assessment.

Doctors treating psychiatric conditions allowed on a claim need to submit progress reports to the claim manager every sixty days (see WAC 296-21-270). If temporary treatment has been authorized for an unrelated psychiatric condition, progress reports need to be submitted to the claim manager every thirty days (see WAC 296-20-055).

NON-COVERED AND BUNDLED PSYCHIATRIC SERVICES

The following services are not covered:

CPT® Code	Abbreviated Description
90802, 90810-90815, 90823-90829 and 90857	Intacpsy dx interview; Intac psytx, off; Intac psytx, off, w/e&m; Intac psytx, hosp; Intac psytx, hosp, w/e&m; Intac psytx group
90845	Psychoanalysis
90846	Family psytx w/o patient
90849	Multiple family group psytx

The following services are bundled and are not payable separately:

CPT® Code	Abbreviated Description
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report

PSYCHIATRIC CONSULTATIONS AND EVALUATIONS

All referrals for psychiatric care require prior authorization (see WAC 296-21-270). This requirement includes referrals for psychiatric consultations and evaluations.

When an authorized referral is made to a psychiatrist, the psychiatrist may bill either the E/M consultation codes (CPT® codes 99241-99275) or the psychiatric diagnostic interview examination code (CPT® code 90801).

When an authorized referral is made to a clinical psychologist for an evaluation, the psychologist may bill only the psychiatric diagnostic interview exam code (CPT® code 90801).

Authorization for CPT® code 90801 is limited to one occurrence every six months, per patient, per provider.

Refer to WAC 296-20-045 and WAC 296-20-051 for more information on consultation requirements.

CASE MANAGEMENT SERVICES

Psychiatrists and clinical psychologists may only bill for case management services (CPT® codes 99361, 99362 and 99371-99373) when providing consultation or evaluation.

Refer to Case Management Services in the Evaluation and Management section for payment criteria and documentation requirements for case management services.

INDIVIDUAL INSIGHT ORIENTED PSYCHOTHERAPY

Individual insight oriented psychotherapy services are divided into services with an E/M component and services without an E/M component. Coverage of these services is different for psychiatrists and clinical psychologists.

Psychiatrists may bill individual insight oriented psychotherapy codes either with or without an E/M component (CPT® codes 90804-90809, 90816-90819 and 90821-90822). Psychotherapy with an E/M component may be billed when services such as medical diagnostic evaluation, drug management, writing physician orders and/or interpreting laboratory or other medical tests are conducted along with psychotherapy treatment.

Clinical psychologists may bill only the individual insight oriented psychotherapy codes without an E/M component (CPT® codes 90804, 90806, 90808, 90816, 90818 and 90821). They may not bill psychotherapy with an E/M component because medical diagnostic evaluation, drug management, writing physician orders and/or interpreting laboratory or other medical tests are outside the scope of clinical psychologist licensure.

Further explanation of this policy and CMS's response to public comments about it are published in *Federal Register* Volume 62 Number 211, issued on October 31, 1997.

Billing Tip

To report individual psychotherapy, use the time frames in the CPT® code descriptions for each unit of service. When billing these codes, do not bill more than one unit per day. When the time frame is exceeded for a specific code, bill the code with the next highest time frame.

USE OF CPT® EVALUATION AND MANAGEMENT CODES FOR PSYCHIATRIC OFFICE VISITS

Psychologists may not bill the E/M codes for office visits.

Psychiatrists may not bill the E/M codes for office visits on the same day psychotherapy is provided for the same patient. If it becomes medically necessary for the psychiatrist to provide an E/M service for a condition other than that for which psychotherapy has been authorized, the provider must submit documentation of the event and request a review before payment can be made.

PHARMACOLOGICAL EVALUATION AND MANAGEMENT

Pharmacological evaluation (CPT® code 90862) is payable only to psychiatrists. If a pharmacological evaluation is conducted on the same day as individual psychotherapy, the psychiatrist must bill the appropriate psychotherapy code with an E/M component. The psychiatrist must not bill the individual psychotherapy code and a separate E/M code in this case (CPT® codes 99201-99215). No payment will be made for psychotherapy and pharmacological management services performed on the same day, by the same physician, on the same patient.

HCPCS code M0064 is not payable in conjunction with the pharmacological evaluation code (CPT® code 90862) or with a CPT® E/M office visit or consultation code (CPT® codes 99201-99215, 99241-99275). The description for HCPCS code M0064 is "Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in treatment of mental psychoneurotic and personality disorders." It will only be payable if these described conditions are accepted by the department as industrially related.

NEUROPSYCHOLOGICAL TESTING

The following three codes may be used if appropriate when performing neuropsychological evaluation. Reviewing records and/or writing and submitting a report is included in these codes and may not be billed separately.

CPT® Code	Abbreviated Description	Billing Restriction
90801	Psy dx interview	May be billed only once every six months.
96100	Psychological testing per hour	May be billed up to a four hour maximum. May be billed in addition to CPT® code 96117.
96117	Neuropsych test battery	May be billed per hour up to a twelve hour maximum.

GROUP PSYCHOTHERAPY SERVICES

Group psychotherapy treatment (CPT® code 90853) is authorized on an individual case-by-case basis only. If authorized, the worker may participate in group therapy as part of his or her individual treatment plan. The department does not pay a group rate to providers who conduct psychotherapy exclusively for groups of injured workers.

If group psychotherapy is authorized and performed on the same day as individual insight oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT® definitions.

NARCOSYNTHESIS AND ELECTROCONVULSIVE THERAPY

Narcosynthesis (CPT® code 90865) and electroconvulsive therapy (CPT® codes 90870 and 90871) require prior authorization. Authorized services are payable only to psychiatrists because they require the administration of medication.

OTHER MEDICINE SERVICES

BIOFEEDBACK

Biofeedback treatment requires an attending doctor's order and prior authorization. Refer to WAC 296-20-03001 for information on what to include when requesting authorization. Rental of home biofeedback devices are time limited and require prior authorization. Refer to WAC 296-20-1102 for the department's policy on rental equipment.

The extent of biofeedback treatment is limited to those procedures allowed within the scope of practice of the licensed and approved biofeedback provider administering the service.

WAC 296-21-280 limits provision of biofeedback to those practitioners who are either certified by the Biofeedback Certification Institute of America (BCIA) or who meet the certification requirements. The WAC also sets forth authorization conditions, treatment limitations and reporting requirements for biofeedback services.

Anyone who is a qualified or certified biofeedback provider as defined in WAC 296-21-280, but is not licensed as a practitioner as defined in WAC 296-20-01002, may not receive direct payment for biofeedback services. These persons may perform biofeedback as paraprofessionals as defined in WAC 296-20-015 under the direct supervision of a qualified, licensed practitioner whose scope of practice includes biofeedback and who is BCIA certified or who meets the certification qualifications. The supervising licensed practitioner must bill the biofeedback services.

When biofeedback is performed in conjunction with individual psychotherapy, use either CPT® code 90875 or 90876 for psycho-physiological therapy; do not bill CPT® codes 90901 or 90911 with the individual psychotherapy codes.

The following table contains the biofeedback codes payable to approved providers:

Code	Abbreviated Description	Payable to:
CPT® 90875	Psychophysiological therapy 20-30 min	Department approved biofeedback providers who are: Clinical Psychologists or Psychiatrists (MD or DO).
CPT® 90876	Psychophysiological therapy 45-50 min	
CPT® 90901(1)	Biofeedback train, any meth	Any department approved biofeedback provider
CPT® 90911(1)	Biofeedback peri/uro/rectal	
HCPCS E0746	Electromyographbiofeedback	DME or pharmacy providers (for rental or purchase). Bundled for RBRVS providers for use in the office.

(1) CPT® codes 90901 and 90911 are not time limited and only one unit of service per day is payable, regardless of the length of the biofeedback session or number of modalities. Use appropriate evaluation and management codes for diagnostic evaluation services. CPT® code 90901 has replaced local codes 1042M and 1043M.

ELECTROMYOGRAPHY (EMG) SERVICES

Payment for needle electromyography (EMG) services (CPT® codes 95860-95870) is limited as follows:

CPT® Code	Abbreviated Description	Limitations
95860	Muscle test, one limb	• Extremity muscles innervated by 3 nerves or 4 spinal levels must be evaluated with a minimum of 5 muscles studied. • Not payable with CPT® code 95870
95861	Muscle test, two limbs	
95863	Muscle test, 3 limbs	
95864	Muscle test, 4 limbs	
95869	Muscle test, thor paraspinal	• May be billed alone (for thoracic spine studies only) • Limited to one unit per day • For this to pay with extremity codes, test must be for T3-T11 areas only; if only T1 or T2 are studied it is not payable separately.
95870	Muscle test, non-paraspinal	• Limited to one unit per extremity and one unit for cervical or lumbar paraspinal muscles regardless of the number of levels tested. • Not payable with extremity codes (5 units maximum payable)

ELECTROCARDIOGRAMS (EKG)

Separate payment is allowed for electrocardiograms (CPT® codes 93000, 93010, 93040 and 93042) when an interpretation and report is included. These services may be paid in conjunction with office services. EKG tracings without interpretation and report (CPT® codes 93005 and 93041) are not payable in addition to office services.

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code R0076) is bundled into the EKG procedure and is not separately payable.

EXTRACORPOREAL SHOCKWAVE THERAPY (ESWT)

The department does not cover extracorporeal shockwave therapy because there is insufficient evidence of effectiveness of ESWT in the medical literature.

VENTILATOR MANAGEMENT SERVICES

No payment will be made for ventilator management services (CPT® codes 94656, 94657, 94660 and 94662) when an E/M service (CPT® codes 99201-99499) is reported on the same day by the same provider. Providers will be paid for either the appropriate ventilation management code or the E/M service, but not both. If a provider bills a ventilator management code on the same day as an E/M service, payment will be made for the E/M service and not for the ventilator management code.

MEDICATION ADMINISTRATION

Immunizations

Refer to WAC 296-20-03005 for authorization and requirements for work related exposure to an infectious disease. If authorized, immunization materials are payable. Immunization administration codes (CPT® codes 90471 and 90472) are payable in addition to the immunization materials code(s). Add-on CPT® code 90472 is limited to a maximum of one unit per day. An E/M code is not payable in addition to the immunization administration service, unless it is performed for a separately identifiable purpose and billed with a -25 modifier. Refer to Provider Bulletin 01-06 for the department's policy on post-exposure prophylaxis for bloodborne pathogens.

Immunotherapy

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. Complete service codes (CPT® codes 95120-95134) will not be paid. The provider must bill as appropriate, one of the injection codes (CPT® codes 95115 or 95117) and one of the antigen/antigen preparation codes (CPT® codes 95145-95149, 95165 or 95170).

Infusion Therapy Services and Supplies for RBRVS Providers

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic or home, regardless of who performs the service. Refer to the Home Health Services section for further information on home infusion therapy.

Outpatient infusion therapy services are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. In these situations, infusion therapy services are payable to physicians, ARNPs, and PAs (CPT® codes 90780 and 90781). HCPCS code Q0081 is only payable to hospitals. Intravenous or intra-arterial therapeutic or diagnostic injection codes (CPT® codes 90783 and 90784) will not be paid separately in conjunction with the IV infusion codes (CPT® codes 90780 and 90781).

Providers will be paid for E/M office visits (CPT® codes 99201-99215) in conjunction with infusion therapy only if the services provided meet the service code definitions.

Billing instructions for non-pharmacy providers are located in Injectable Medications later in this section. Drugs supplied by a pharmacy must be billed on pharmacy forms with national drug codes (NDCs or UPCs if no NDC is available).

Infusion therapy supplies and related durable medical equipment such as infusion pumps are not separately payable for RBRVS providers. Payment for these items is bundled into the fee for the professional service. If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the Home Health Services section for further information.

The department does **not** cover implantable infusion pumps and supplies (HCPCS codes A4220, E0782, E0783, E0785 and E0786). The department also does **not** cover the implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal (CPT® codes 62350-62368).

NOTE: When a spinal cord injury is an accepted condition, the department or Self-Insurer may authorize payment for anti-spasticity medications by any indicated route of administration (e.g., some benzodiazepines, Baclofen). Prior authorization is required.

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of mediations are covered services with CPT® 62310-62319, 62281-62284 and 62290-62294.

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material are not covered (see WAC 296-20-03002). Infusion of any opiates and their derivatives (natural, synthetic or semi-synthetic) are not covered unless they are part of providing anesthesia, short term post operative pain management (up to 48 hours post discharge), or unless medically necessary in emergency situations (see WAC 296-20-03014). No exceptions to this payment policy will be granted.

Therapeutic or Diagnostic Injections

Professional services associated with therapeutic or diagnostic injections (CPT® code 90782 or 90788), are payable along with the appropriate HCPCS "J" code for the drug, as long as no E/M office visit service (CPT® codes 99201-99215) is provided on the same day. If an E/M office visit service is provided on the same day as an injection, providers will be paid only the E/M service and the appropriate HCPCS "J" code for the drug. Providers must document the name, strength, dosage and quantity of the drugs administered in the medical record.

Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT® codes 90783 and 90784) may be billed separately and are payable if they are not provided in conjunction with IV infusion therapy services (CPT® codes 90780 and 90781).

NOTE*:* Injections of narcotics or analgesics are not permitted or paid in the outpatient setting except on an emergency basis (see WAC 296-20-03014) or for pain management related to outpatient surgical procedures and dressing and cast changes for severe soft tissue injuries, burns or fractures.

Dry needling is considered a variant of trigger point injections with medications. Dry needling is a technique where needles inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services
(see WAC 296-20-03002). Dry needling of trigger points must be billed using trigger point injection CPT® codes 20552 or 20553. Dry needling follows the same rules as trigger point injections in WAC 296-20-03001(14).

Injectable Medications

Providers must use the "J" codes for injectable drugs that are administered during an E/M office visit or other procedure. The "J" codes are not intended for self-administered medications.

When billing for a non-specific injectable drug, the name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record.

Providers must bill their acquisition cost for the drugs. Department fees for injectable medications are based on the AWP. Payment is made according to the published fee schedule amount, or the billed charge for the covered drug(s), whichever is less.

Hyaluronic Acid for Osteoarthritis of the Knee

Hyaluronic acid injections are indicated only for osteoarthritis of the knee. Other uses are considered experimental, and therefore will not be paid.(see WAC 296-20-03002(6)).

Hyaluronic acid injections must be billed with CPT® injection procedure code 20610 and the appropriate HCPCS code (J7320 for Synvisc injections or J7317 for Hyalgan or Supartz injections).

The correct side of body modifier (-RT or -LT) is required for authorization and billing. If bilateral procedures are required, both modifiers must be authorized and each must be billed as a separate line item.

See Provider Bulletin 98-10 for more information about the use of hyaluronic acid for osteoarthritis of the knee.

Non-Injectable Medications

Providers may administer oral or non-injectable medications during office procedures or dispense them for short-term use until the worker can have their prescription filled at a pharmacy. In these cases, providers must bill the distinct "J" code that describes the medication. If no distinct "J" code describes the medication, the most appropriate non-specific HCPCS code listed below must be used:

HCPCS Code	Brief Description
J3535	Metered dose inhaler drug
J7599	Immunosuppressive drug, noc
J7699	Inhalation solution for DME
J7799	Non-inhalation drug for DME
J8499	Oral prescrip drug non-chemo
J8999	Oral prescription drug chemo

The name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record. No payment will be made for pharmaceutical samples.

OBESITY TREATMENT

While obesity does not meet the definition of an industrial injury or occupational disease, temporary treatment of obesity may be allowed in some cases. All obesity treatment services require prior authorization. The department pays for obesity treatment by reimbursing the worker using the following codes:

Code	Description	Fee Limits
0440A	Weight loss program, joining fee, worker reimbursement	$ 136.47
0441A	Weight loss program, weekly fee, worker reimbursement	$ 27.30

The attending doctor may request a consultation with a registered dietitian or nutritionist (RD) to determine if an obesity treatment program is appropriate for the injured worker. Only RDs will be reimbursed for nutrition counseling services. Providers practicing in another state who are similarly certified or licensed may apply to be considered for reimbursement. RDs that do not already have a provider number may call the Provider Hotline at 1-800-848-0811 for a provider application. The RD may bill for authorized services using CPT® code 97802 or 97803. Both CPT© 97802 and 97803 are billed in 15 minute units. CPT© 97802 can be billed only for the initial visit, up to a maximum of 4 units. CPT© 97803 is billed up to a maximum of 2 units per visit with a maximum of 3 follow-up visits.

Code	**Abbreviated Description**	**Fee Limits**
CPT® 97802	Medical nutrition, indiv, in	$ 24.30
CPT® 97803	Medical nutrition, indiv, subseq	$ 24.30

IMPAIRMENT RATING EXAM AND REPORT BY ATTENDING DOCTORS AND CONSULTANTS

These local codes are for use by attending doctors who are doctors of medicine, osteopathic medicine and surgery, chiropractic, podiatry and dentistry. In accordance with WAC 296-23-267, doctors of naturopathy and optometry may not bill these codes. For more information on impairment rating, refer to the *Medical Examiners Handbook*.

Consultants performing impairment ratings must be on the department's list of approved examiners.

Code	**Description**	**Maximum Fee**
1190M	Impairment rating exam and report by attending doctor, limited	$ 221.62
1191M	Impairment rating exam and report by attending doctor, standard	$ 322.37
1192M	Impairment rating exam and report by attending doctor, complex	$ 402.95
1193M	Impairment rating exam and report by consultant, limited	$ 221.62
1194M	Impairment rating exam and report by consultant, standard	$ 322.37
1195M	Impairment rating exam and report by consultant, complex	$ 402.95

PHYSICIAN ASSISTANTS

Physician assistants must be certified to qualify for payment. Physician assistants must have valid individual L&I provider account numbers to be paid for services.

Consultations, impairment ratings and administrative or reporting services related to workers' compensation benefit determinations are not payable to physician assistants. Physician assistant services are paid to the supervising physician or employer at a maximum of 90% of the allowed fee.

Further information about physician assistant services and payment can be found in Provider Bulletin 99-04 and WAC 296-20-12501 and WAC 296-20-01501.

NATUROPATHIC PHYSICIANS

Naturopathic physicians must use the E/M CPT® codes to bill for office visit services, CPT® codes 99361-99373 to bill for case management services and the appropriate HCPCS codes to bill for miscellaneous materials and supplies.

USE OF CPT® EVALUATION AND MANAGEMENT CODES FOR NATUROPATHIC OFFICE VISITS

Naturopathic physicians may bill the first four levels of CPT® new and established patient office visit codes (99201-99204 and 99211-99214). The department uses the CPT® definitions for new and established patients. If a provider has treated a patient for any reason within the last three years, the person is considered an established patient. Refer to a CPT® book for complete code descriptions, definitions and guidelines.

Refer to Case Management Services in the Evaluation and Management section for payment criteria and documentation requirements for case management services.

The department will not pay naturopathic physicians for services that are not specifically allowed. Refer to Chapter 296-23 WAC for additional information.

PATHOLOGY AND LABORATORY SERVICES

PANEL TESTS

Automated Multichannel Tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

The following tests are automated multichannel tests or panels comprised solely of automated multichannel tests:

CPT®	Abbreviated Description
80048	Basic metabolic panel
80051	Electrolyte panel
80053	Comprehensive metabolic panel
80069	Renal function panel
80076	Hepatic function panel
82040	Assay of serum albumin
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82465	Assay of serum cholesterol
82550	Creatine kinase (CK) (CPK)
82565	Assay of creatine

CPT®	Abbreviated Description
82947	Assay of glucose, qualitative
82977	Assay of GGT
83615	Lactate (LD) (LDH) enzyme
84075	Assay alkaline phosphatase
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay pf protein
84295	Assay of serum sodium
84450	Transferase (AST) (SGOT)
84460	Alanine amino (ALT) (SGPT)
84478	Assay of triglycerides
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid

Payment Calculation for Automated Tests

The automated individual and panel tests above will be paid based on the total number of unduplicated automated multichannel tests performed per day per patient. Payment calculation is made according to the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined;
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day;
- Any duplicated tests are denied;
- Then the total number of remaining unduplicated automated tests is counted. See the following table to determine the payable fee based on the total number of unduplicated automated tests performed:

Number of Tests	Fee
1 test	Lower of the single test or $10.19
2 tests	$10.19
3 -12 tests	$12.50
13 -16 tests	$16.69

Number of Tests	Fee
17 – 18 Tests	$18.70
19 Tests	$21.63
20 Tests	$22.33
21 Tests	$23.03
22 –23 Tests	$23.73

Payment Calculation for Panels with Automated and Non-Automated Tests

When panels are comprised of both automated multichannel tests and individual non-automated tests, they will be priced based on:

- The automated multichannel test fee based on the number of tests, added to
- The sum of the fee(s) for the individual non-automated test(s).

For example, panel test 80061 is comprised of two automated multichannel tests and one non-automated test. As shown below, the fee for 80061 is **$26.21.**

CPT® 80061 Component Tests	Number of Automated Tests	Maximum Fee
Automated: CPT® 82465 CPT® 84478	2	Automated: $ 10.19
Non-Automated: CPT® 83718		Non-Automated: $ 16.02
MAXIMUM PAYMENT:		$ 26.21

Payment Calculation for Multiple Panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be limited to the total fee allowed for the unduplicated component tests.

Example:

The table below shows how the maximum payment would be calculated if panel codes 80050, 80061 and 80076 were billed with individual test codes 82977, 83615, 84439 and 85025.

Test	CPT® PANEL CODES			INDIVIDUAL TESTS	Test Count	Max Fee
	80050	80061	80076			
Automated Tests	82040 84075 82247 84132 82310 84155 82374 84295 82435 84450 82565 84460 82947 84520	82465 84478	82040(1) 82247(1) 82248 84075(1) 84155(1) 84450(1) 84460(1)	82977 83615	19 Unduplicated Automated Tests	$ 21.63
Non-Automated Tests	84443 85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009	83718	None	84439 85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009 (1)		$ 32.75 $ 15.20 $ 16.02 $ 17.11 $ 0.00
MAXIMUM PAYMENT:						$ 81.08

(1) Duplicated tests

REPEAT TESTS

Additional payment will be allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) must be taken from separate encounters. Test(s) normally performed in a series (e.g., glucose tolerance tests or repeat testing of abnormal results do not qualify as separate encounters). The medical necessity for repeating the test must be documented in the patient's record.

Modifier –91 must be used to identify the repeated test(s). Payment for repeat panel tests or individual components tests will be made based on the methodology described above.

SPECIMEN COLLECTION AND HANDLING

Specimen collection charges are allowed for provider or practitioner, independent laboratory or outpatient hospital laboratory services as follows:

- The fee is payable only to the provider (practitioner or laboratory) who actually draws the specimen.
- Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee who is qualified to do specimen collection performs the draw.
- Payment for performing the test is separate from the specimen collection fee.
- Costs for media, labor and supplies (e.g., gloves, slides, antiseptics, etc.) are included in the specimen collection.
- A collection fee is not allowed when the cost of collecting the specimen(s) is minimal, such as a throat culture, Pap smear or a routine capillary puncture for clotting or bleeding time.
- No fee is payable for specimen collection performed by patients in their homes (such as stool sample collection).

Billing Tip

Use CPT® code 36415 or HCPCS code G0001 for venipuncture. Use HCPCS code P9612 or P9615 for catheterization for collection of specimen.

Complex vascular injection procedures, such as arterial punctures and venisections, are not subject to this policy and will be paid with the appropriate CPT® or HCPCS codes.

No payment for travel will be made to nursing home or skilled nursing facility staff who perform the specimen collection. Travel will be paid in addition to the specimen collection fee when **all** of the following conditions are met:

- It is medically necessary for a provider, practitioner or laboratory technician to draw a specimen from a nursing home, skilled nursing facility or homebound patient, and
- the provider, practitioner or lab technician personally draws the specimen, and
- the trip is solely for the purpose of collecting the specimen.

If the specimen draw is incidental to other services, no travel is payable.

Billing Tip

Use HCPCS code P9603 to bill for actual mileage (one unit equals one mile). HCPCS code P9604 is not covered.

Payment will not be made for handling and conveyance, e.g., shipping or messenger or courier service of specimen(s) (CPT® codes 99000 and 99001). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These services are considered to be integral to the testing process and are bundled into the total fee for the testing service.

STAT LAB FEES

Usual laboratory services are covered under the Professional Services Fee Schedule. In cases where laboratory tests are appropriately performed on a STAT basis, the provider may bill HCPCS code S3600 or S3601. Payment is limited to one STAT charge per episode (not once per test). Tests ordered STAT should be limited to only those that are needed to manage the patient in a true emergency situation. The laboratory report should contain the name of the provider who ordered the STAT test(s). The medical record must reflect the medical necessity and urgency of the service.

The STAT charge will only be paid with the tests listed below.

CPT® Code	Abbreviated Description
80048	Basic metabolic panel
80051	Electrolyte panel
80069	Renal function panel
80076	Hepatic function panel
80100	Drug screen
80101	Drug screen
80156	Assay of carbamazepine
80162	Assay of digoxin
80164	Assay, dipropylacetic acid
80170	Assay of gentamicin
80178	Assay of lithium
80184	Assay of phenobarbital
80185	Assay of phenytoin, total
80188	Assay of primidone
80192	Assay of procainamide
80194	Assay of quinidine
80196	Assay of salicylate
80197	Assay of tacrolimus
80198	Assay of theophylline
81000	Urinalysis, nonauto w/scope
81001	Urinalysis, auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis, auto, w/o scope
81005	Urinalysis
82003	Assay of acetaminophen
82009	Test for acetone/ketones
82040	Assay of serum albumin
82055	Assay of ethanol
82150	Assay of amylase
82247	Bilirubin, total
82248	Bilirubin, direct
82310	Assay of calcium
82330	Assay of calcium
82374	Assay, blood carbon dioxide
82435	Assay of blood chloride
82550	Assay of ck (cpk)
82565	Assay of creatinine
82803	Blood gases: pH, pO2 & pCO2
82945	Glucose other fluid
82947	Assay of glucose, quant

CPT® Code	Abbreviated Description
83874	Assay of myoglobin
83880	Natriuretic peptide
84100	Assay of phosphorus
84132	Assay of serum potassium
84155	Assay of protein
84157	Protein, total, other source
84295	Assay of serum sodium
84302	Assay of sweat sodium
84450	Transferase (AST) (SGOT)
84484	Assay of troponin, quant
84512	Assay of troponin, qual
84520	Assay of urea nitrogen
84550	Assay of blood/uric acid
84702	Chorionic gonadotropin test
85004	Automated diff wbc count
85007	Differential WBC count
85025	Automated hemogram
85027	Automated hemogram
85032	Manual cell count, each
85046	Reticucytes/hgb concentrate
85049	Automated platelet count
85378	Fibrin degradation
85380	Fibrin degradation
85384	Fibrinogen
85396	Coagulation/fibrinolysis assay
85610	Prothrombin time
85730	Thromboplastin time, partial
86308	Heterophile antibodies
86403	Particle agglutination test
86880	Coombs test
86900	Blood typing, ABO
86901	Blood typing, Rh (D)
86920	Compatibility test
86921	Compatibility test
86922	Compatibility test
86971	RBC pretreatment
87205	Smear, stain & interpret
87210	Smear, stain & interpret
87281	Pneumocystis carinii, ag, if
87327	Cryptococcus neoform ag, eia

CPT® Code	Abbreviated Description
83615	Lactate (LD) (LDH) enzyme
83663	Fluoro polarize, fetal lung

CPT® Code	Abbreviated Description
87400	Influenza a/b, ag, eia
89051	Body fluid cell count

HCPCS Code	Abbreviated Description
G0306	Complete CBC, auto w/diff
G0307	Complete CBC, auto

PHARMACY AND DURABLE MEDICAL EQUIPMENT SERVICES

PHARMACY FEE SCHEDULE

Payment for drugs and medications, including all oral non-legend drugs, will be based on the pricing methodology described below. Refer to WAC 296-20-01002 for definitions of AWP and BLP.

The department's outpatient formulary can be found in **Appendix G** at the end of this document.

Drug Type	Payment Method
Generic	The lesser of BLP or AWP less 10% + $ 4.50 Professional Fee
Brand with Generic Equivalent (Substitution Allowed)	The lesser of BLP or AWP less 10% + $ 3.00 Professional Fee
Brand with Generic Equivalent (Dispensed as Written)	AWP less 10% + $ 4.50 Professional Fee
Single or multi-source brand name drugs	AWP less 10% + $ 4.50 Professional Fee

Compounded prescriptions will be paid at the allowed cost of the ingredients plus a compounding time fee of $4.00 per 15 minutes and a $4.50 professional fee.

Orders for over-the-counter non-oral drugs or non-drug items must be written on standard prescription forms. These items are to be priced on a 40% margin.

Prescription drugs and oral or topical over-the-counter medications are nontaxable (RCW 82.08.0281).

EMERGENCY CONTRACEPTIVES AND PHARMACIST COUNSELING

The department covers Emergency Contraceptive Pills (ECPs) and associated pharmacist counseling services when **all** of the following conditions are met:

- A valid claim for rape in the workplace is established with the insurer, and
- The ECP and/or counseling service is sought by the injured worker, and
- The claim manager authorizes payment for the ECP and/or the counseling, and
- The pharmacist is approved by the Department of Health Board of Pharmacy to follow this particular protocol.

Once these conditions have been met, the dispensed medication must be billed with the appropriate NDC and the counseling service with HCPCS code S9445.

INFUSION THERAPY

Services

The department will only pay home health agencies and/or independent registered nurses for infusion therapy services (CPT® codes 90780 and 90781) and/or therapeutic, diagnostic, vascular injections (CPT® codes 90782-90788 and 36000-36640). These services require prior authorization.

Supplies

Only pharmacies and DME suppliers, including IV infusion companies, may be paid for infusion therapy supplies. Supplies (including infusion pumps) require prior authorization and must be billed with HCPCS codes. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

Drugs

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with NDC codes or UPC codes if no NDC codes are available.

DURABLE MEDICAL EQUIPMENT (DME)

Pharmacies and DME providers may bill for supplies and equipment with appropriate HCPCS and local codes. Delivery charges, shipping and handling, tax and fitting fees are not payable separately. DME suppliers should include these charges in the total charge for the supply. For taxable items, an itemized invoice may be attached to the bill but is not required.

DME suppliers may bill for equipment and supplies required to provide authorized IV infusion therapy under their L&I DME provider account number. Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps.

The department pays for TENS units, services and supplies under contract only. Refer to the TENS section for more information.

For further information on miscellaneous services and appliances, refer to WAC 296-23-165.

BUNDLED CODES

Covered HCPCS codes listed as **bundled** in the fee schedules are payable to pharmacy and DME providers because there is no office visit or procedure associated with these provider types into which supplies can be bundled.

HOME HEALTH SERVICES

Attendant service, home health and hospice providers should use the codes listed in this section to bill for services. All of these services require prior authorization. The insurer will pay only for proper and necessary care and supplies needed because of physical restrictions caused by the industrial injury or disease. The insurer will not pay for services that are not specifically authorized.

Chore services and other services required to meet the worker's environmental needs are not covered except for home hospice care.

ATTENDANT SERVICES

Attendant services are proper and necessary personal care services provided to maintain the injured worker in his or her residence. All attendant services must be provided through a home health or home care agency except for spouses who provided department approved attendant services to their spouse prior to October 1, 2001. Spouses who met department criteria prior to the end of year 2002 may continue to provide non-agency care to their spouse. To be covered by the department, attendant services must be requested by the attending physician and authorized by the department before care begins.

The department will determine the maximum hours of authorized attendant services based on an independent nursing assessment of the worker's care needs. Refer to WAC 296-23-246 and Provider Bulletin 01-08 for additional information.

Covered Services

The insurer will approve hours of care based on an independent nursing evaluation. Respite care must be approved in advance. The following are examples of covered home health care services:

- Administration of medications
- Assistance with basic range of motion exercises
- Bathing and personal hygiene
- Bowel and incontinent care
- Dressing
- Feeding assistance (not meal preparation)
- Mobility assistance including walking, toileting and other transfers
- Specialized skin care including caring for or changing dressings or ostomies
- Tube feeding
- Turning and positioning

Non-Covered Services

Chore services and other services required to meet the worker's environmental needs are not covered. The following services are considered to be chore services:

- Childcare
- Shopping and other errands for the injured worker
- Yard work
- Laundry and other housekeeping activities
- Meal planning and preparation
- Transportation of the injured worker
- Recreational activities
- Other everyday environmental needs unrelated to the medical care of the injured worker

Attendant Service Codes

Code	Description	Fee
8901H	Attendant services by department approved spouse provider, per hour	$ 11.27
G0156	Services of home health aide in home health setting, each 15 minutes	$ 5.73

Additional Home Health Codes

Code	Description	Fee
8907H	Home health agency visit (RN), per day	$ 131.66
8912H	Home health agency visit (RN), each additional visit, per day	$ 55.37
G0151	Services of physical therapist in home health setting, each 15 minutes (1 hour limit per day)	$ 32.91
G0152	Services of occupational therapist in home health setting, each 15 minutes (1 hour limit per day)	$ 34.11
G0153	Services of speech and language pathologist in home health setting, each 15 minutes (1 hour limit per day)	$ 34.11
S9124	Nursing care, in the home by licensed practical nurse, per hour	$ 36.41

Nursing Evaluations

Independent nursing evaluations, when requested by the department or Self-Insurer, may be billed under Nurse Case Manager or Home Health Agency Visit (RN) codes, using their respective codes.

HOSPICE SERVICES

In-home hospice services must be preauthorized and may include chore services. For hospice services performed in a facility, please refer to Nursing Home, Hospice and Residential Care in the Facility Section. The following code applies to in-home hospice care:

Code	Description	Fee
S9126	Hospice care, in the home, per diem	BR

HOME INFUSION THERAPY SERVICES

Prior authorization is required for all scheduled or ongoing infusion therapy services, supplies and drugs provided in the home, regardless of who provides the service. Payment for performing home infusion therapy and injections of medication is included with the allowed payment for home health agency nursing services and may not be billed separately.

Refer to WAC 296-20-1102 for information on the rental or purchase of infusion pumps, which must be billed with HCPCS codes.

Infusion therapy drugs, including injectable drugs, are payable only to pharmacies. Drugs must be authorized and billed with NDC codes or UPC codes if no NDC codes are available.

SUPPLIES, MATERIALS AND BUNDLED SERVICES

Services and supplies must be medically necessary and must be prescribed by an approved provider for the direct treatment of a covered condition.

CPT® code 99070, which represents miscellaneous supplies and materials provided by the physician, will not be paid. Providers must bill specific HCPCS or local codes for supplies and materials provided during an office visit or with other office services.

Under the fee schedules, some services and supply items are considered bundled into the cost of other services (associated office visits or procedures) and will not be paid separately. See WAC 296-20-01002 for the definition of a bundled code. Bundled codes are listed as bundled in the dollar value column in the Professional Services Fee schedule. Refer to **Appendices B and C** for lists of bundled services and supplies.

ACQUISITION COST POLICY

Supply codes that do not have a fee listed will be paid at their acquisition cost. The acquisition cost equals the wholesale cost plus shipping and handling and sales tax. These items must be billed together as one charge. For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill but is not required.

Wholesale invoices for all supplies and materials must be retained in the provider's office files for a minimum of five years. A provider must submit a hard copy of the wholesale invoice to the department or Self-Insurer when an individual supply item costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Supplies used in the course of an office visit are considered bundled and are not payable separately. Fitting fees are bundled into the office visit or into the cost of any DME and are not payable separately.

Sales tax and shipping and handing charges are not paid separately, and must be included in the total charge for the supply. An itemized statement showing net price plus tax may be attached to bills but is not required.

CASTING MATERIALS

Providers should bill for casting materials with HCPCS codes Q4001-Q4051. The department no longer accepts HCPCS codes A4580-A4590 or local codes 2978M-2987M. No payment will be made for the use of a cast room. Use of a cast room is considered part of a provider's practice expense.

MISCELLANEOUS SUPPLIES

The following supplies were formerly billed with local codes and must be billed with HCPCS Code E1399:

- Therapeutic exercise putty
- Rubber exercise tubing
- Anti-vibration gloves

CATHETERIZATION

Separate payment is allowed for placement of a temporary indwelling catheter (CPT® codes 51702 and 51703) when performed in a provider's office and used to treat a temporary obstruction. Payment for the service is not allowed when the procedure is performed on the

same day or during the postoperative period of a major surgical procedure that has a follow-up period.

For catheterization to obtain specimen(s) for lab tests, see the Pathology and Laboratory Services section.

SURGICAL TRAYS AND SUPPLIES USED IN THE PHYSICIAN'S OFFICE

The department follows CMS's policy of bundling HCPCS codes A4263, A4300 and A4550 for surgical trays and supplies used in a physician's office.

SURGICAL DRESSINGS DISPENSED FOR HOME USE

The cost for surgical dressings that are applied during a procedure, office visit or clinic visit is included in the practice expense component of the RVU (overhead) for that provider. No separate payment is allowed.

Primary and secondary surgical dressings dispensed for home use are payable at acquisition cost when **all** of the following conditions are met:

- They are dispensed to a patient for home care of a wound, and
- They are medically necessary, and
- The wound is due to an accepted work related condition.

Primary Surgical Dressings

Primary surgical dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Examples of primary surgical dressings include items such as Telfa, adhesive strips for wound closure and petroleum gauze.

Secondary Surgical Dressings

Secondary surgical dressings serve a therapeutic or protective function and secure primary dressings. Examples include items such as adhesive tape, roll gauze, binders and disposable compression material. They do not include items such as elastic stockings, support hose and pressure garments. These items must be billed with the appropriate HCPCS or local codes.

Providers must bill the appropriate HCPCS code for each dressing item, along with the local modifier –1S for each item. Surgical dressing supplies and codes billed without the local modifier –1S are considered bundled and will not be paid.

HOT AND COLD PACKS OR DEVICES

Application of hot or cold packs (CPT® code 97010) is bundled for all providers.

WAC 296-20-1102 prohibits payment for heat devices for home use including heating pads. These devices are either bundled or not covered (see **Appendices B, C and D**).

OTHER SERVICES

AUDIOLOGY AND HEARING AID SERVICES

Information about the department's hearing aid services and devices reimbursement policies and rates can be found in Provider Bulletin 01-09.The Bulletin is available online at http://www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp

Caution Against Misleading Advertisements

The department may deny applications of health care providers to participate as a provider of services to injured workers, or terminate or suspend providers' eligibility to participate if the provider uses, causes or promotes the use of advertising matter, promotional materials or other representation, however disseminated or published, that is false, misleading or deceptive with respect to the industrial insurance system or benefits for injured workers (see RCW 51.36.130).

Hearing Loss Claims

The attending physician must validate the existence of a job related hearing loss. The physician may test or refer the injured worker to an otolaryngologist (ear, nose and throat specialist) or certified audiologist for hearing tests to determine whether there is a work related hearing loss.

The department or Self-Insurer will furnish hearing aids only when prescribed by a physician (see WAC 296-20-1101). The doctor must examine the worker prior to the department's hearing aid authorization.

The attending physician must submit a packet to the department containing **all** of the following:

- Report of Accident form, and
- Hearing Loss Work History form, and
- Copy of the valid audiogram, and
- Medical report.

The department or Self-Insurer needs all of the above information to approve or deny a hearing loss claim.

Hearing Aid Billing Codes

All hearing aids and supplies must be billed using HCPCS codes. Local codes are no longer valid. The department will only purchase the hearing aids described in the codes shown in the fee schedule.

When billing for hearing aids, indicate the following on the billing form:

- The diagnosis, as appropriate, for each side of the body.
- The appropriate HCPCS code for monaural or binaural aids. Only one unit of service should be billed, whether one (monaural aid) or two hearing aids (binaural aids) are dispensed.

AFTER HOURS SERVICES

After hours services (CPT® codes 99050-99054) will only be considered for separate payment when the provider's office is not regularly open. Only one after hours service code will be reimbursed per patient per day. After hours service codes are not payable when billed by emergency room physicians, anesthesiologists/anesthetists, radiologists and laboratory clinical staff. The medical necessity and urgency of the service must be documented in the medical records and be available upon request.

INTERPRETER SERVICES

These local codes are for use by interpreters who provide language communication between injured workers and medical or vocational service providers. Refer to

Provider Bulletins 03-01 and 03-10 for complete payment and eligibility information.

Code	Description	Maximum Fee	Code Limits
9986M	Interpreter mileage, per mile.	State employees' mileage rate	Mileage billed beyond 50 miles per day per claim and total mileage beyond 75 miles per day, to include all claims, will be a basis for review.
9989M	Interpreter services provided directly between the health care or vocational provider and the claimant, per minute.	$ 1.00 per minute	Billed time greater than 8 hours per day will be a basis for review.
9990M	Time spent assisting claimant with completion of insurer form, per minute, outside of the time spent with the provider of health or vocational services.	$ 1.00 per minute	
9991M	Wait time for an appointment that does not begin at the scheduled time, per minute.	$ 0.50 per minute	Billed time greater than 60 minutes will be a basis for review.
9996M	Interpreter "no show" wait time when a worker does not attend an insurer-requested IME, per minute.	$ 0.50 per minute	Billed time greater than 60 minutes will be a basis for review.
9997M	Document translation at insurer request, per minute.	$ 1.00 per minute	

MEDICAL TESTIMONY AND DEPOSITIONS

The Office of the Attorney General or the Self-Insurer makes arrangements with expert witnesses to provide testimony or deposition. Bills for these services should be submitted directly to the Office of the Attorney General or Self-Insurer. Although the department does not use codes for medical testimony, Self-Insurers must allow providers to use CPT® code 99075 to bill for these services.

Fees are calculated on a portal-to-portal time basis (from the time you leave your office until you return), which does not include side trips.

The time calculation for testimony or deposition performed in the provider's office or via phone is based upon the actual time used for the testimony or deposition.

The Office of the Attorney General, not the department, determines testimony fee and payment policies.

Testimony fees (applied to doctors as defined in WAC 296-20-01002)

Description	Maximum Fee
Medical testimony approved in advance by Office of the Attorney General, first hour	$ 384.41
Each additional 30 minutes	$ 128.14
Deposition approved in advance by Office of Attorney General, first hour	$ 320.35
Each additional 30 minutes	$ 107.31

Testimony fees (applied to all other health care providers)

Description	Maximum Fee
Medical testimony approved in advance by Office of the Attorney General, first hour	$ 80.00
Each additional 30 minutes	$ 40.00
Deposition approved in advance by Office of Attorney General, first hour	$ 80.00
Each additional 30 minutes	$ 40.00

Cancellation policy for testimony or depositions

Cancellation Date	Cancellation Fee
3 working days or less than 3 working days notice before a hearing or deposition	Department will pay a cancellation fee for the amount of time you were scheduled to testify, at the allowable rate.
More than 3 working days notice before a hearing or deposition	Department will not pay a cancellation fee.

NURSE CASE MANAGEMENT

All nurse case management services require prior authorization. Refer to Provider Bulletin 98-01 for a complete description of the services, provider qualifications and billing instructions.

Nurse case managers must use the following local codes to bill for nurse case management services, including nursing assessments:

Code	Description	Maximum Fee
1220M	Phone calls, per 6 minute unit	$ 8.50
1221M	Visits, per 6 minute unit	$ 8.50
1222M	Case planning, per 6 minute unit	$ 8.50
1223M	Travel/Wait, per 6 minute unit	$ 4.18
1224M	Mileage, per mile	State rate
1225M	Expenses (parking, ferry, toll fees, lodging and airfare) at cost or state per diem rate (lodging)	

Nurse case management services are capped at 50 hours of service, including professional and travel/wait time. An additional 25 hours may be authorized after staffing with the insurer. Further extensions may be granted in exceptional cases, contingent upon review by the insurer.

REPORTS AND FORMS

Providers should use the following CPT® or local codes to bill for special reports or forms required by the department or Self-Insurer. The fees listed below include postage for sending documents to the department or Self-Insurer:

Code	Report/Form	Maximum Fee	Special notes
CPT® 99080	Special Report (Sixty Day Report)	$ 33.55	Sixty day reports are required per WAC 296-20-06101 and do not need to be requested by the insurer. Not payable for records required to support billing or for review of records included in other services. Limit of one per day.
CPT® 99080	Special Report (Requested by insurer or VRC)	$ 33.55	**Must be requested by insurer or vocational counselor.** Not payable for records or reports required to support billing or for review of records included in other services. Do not use this code for forms or reports with assigned codes. Limit of one per day.
1026M	Attending Physician Final Report (PFR)	$ 33.55	**Must be requested by insurer.** Payable only to attending doctor. Not paid in addition to office visit on same day. Form will be sent from insurer. Provider must retain copy of completed form. Limit of one per day.
1027M	Loss of Earning Power (LEP)	$ 9.44	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per day.
1037M	Physical Capacity Evaluation (PCE) or Restrictions	$ 21.42	**Must be requested by State Fund employer.** Payable to attending doctor, the treating physician assistant or advanced registered nurse practitioner. Use for State Fund claims only. Bill to the department (see Provider Bulletin 96-10).
1039M	Time Loss Notification (TLN)	$ 9.44	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per day.
1040M	Report of Industrial Injury or Occupational Disease/ Report of Accident (ROA) – for State Fund claims	$ 25.69	Payable only to attending doctor. Paid when initiated by the injured worker or attending doctor. Limit of one per claim.
1040M	Physician's Initial Report – for Self Insured claims	$ 25.69	Payable only to attending doctor. Paid when initiated by the injured worker or attending doctor. Limit of one per claim.
1041M	Application to Reopen Claim	$ 25.69	Payable only to attending doctor. May be initiated by the injured worker or insurer (see WAC 296-20-097). Limit of one per request.

Code	Report/Form	Maximum Fee	Special notes
1048M	Doctor's Estimate of Physical Capacities	$ 21.42	**Must be requested by insurer or vocational counselor**. Payable to attending doctor, independent medical examiners, consultants, the treating physician assistant or advanced registered nurse practitioner. Limit of one per day per claim.
1055M	Occupational Disease History Form	$ 161.86	**Must be requested by insurer.** Payable only to attending doctor. Includes review of claimant information and preparation of report on relationship of occupational history to present condition(s).
1056M	Supplemental Medical Report (SMR)	$ 15.88	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per day.
1057M	Opioid Progress Report Supplement	$ 15.88	Payable only to attending physician. Paid when the worker is prescribed opioids for chronic, non-cancer pain. Must be submitted at least every 60 days (see WACs 296-20-03021, -03022 and Provider Bulletin 00-04). Limit of one per day.
1063M	Attending Doctor Review of Independent Medical Exam (IME)	$ 34.27	**Must be requested by insurer.** Payable only to attending doctor. Limit of one per request.
1064M	Initial report documenting need for opioid treatment	$ 33.55	Payable only to the attending physician. Paid when initiating opioid treatment for chronic, non-cancer pain. See WAC 296-20-03020 and Provider Bulletin 00-04 for what to include in the report.

More information on some of the reports and forms listed above is provided in WAC 296-20-06101. Many department forms are available online at http://www.LNI.wa.gov/FormPublications/ and all reports and forms may be requested from the Provider Hotline at 1-800-848-0811. When required, the department or Self-Insurer will send special reports and forms.

COPIES OF MEDICAL RECORDS

Providers may bill for copies of medical records requested by the department, Self-Insurer or Self-Insurer representative using HCPCS code S9982. Payment for S9982 includes all costs, including postage. S9982 is not payable for services required to support billing or to commercial copy centers or printers who reproduce records for providers.

Only providers who have provided health care or vocational services to the injured worker may bill HCPCS code S9982. The insurer will pay for requested copies of medical records, regardless of whether the provider is currently treating the injured worker or has treated the worker at some time in the past, including prior to the injury. If the insurer requests records from a health care provider, the insurer will pay for the requested services. Payment will be made per copied page.

PROVIDER MILEAGE

Providers may bill for mileage when a round trip exceeds 14 miles.

Code	Description	Maximum Fee
1046M	Mileage, per mile, allowed when round trip exceeds 14 miles	$ 4.29

REVIEW OF JOB OFFERS AND JOB ANALYSES

A **job offer** is based on an employer's desire to offer a specific job to a worker. The job offer may be based on a job description or a job analysis. For more information about job offers, see RCW 51.32.09(4).

A **job description** is an employer's brief evaluation of a specific job or type of job that the employer intends to offer a worker.

A **job analysis (JA)** is a detailed evaluation of a specific job or type of job. A JA is used to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience, non-work related skills and physical limitations or to determine the injured worker's ability to perform a specific job. The job evaluated in the JA may or may not be offered to the worker and it may or may not be linked to a specific employer.

Attending doctors, independent medical examiners (IME) and consultants will be paid for review of job descriptions or JA's. A job description/JA review may be performed at the request of the State Fund employer, the insurer, vocational rehabilitation counselor (VRC) or third party administrator (TPA) acting for the insurer or the employer. Reviews requested by other persons (e.g., attorneys or injured workers) will not be paid. This service does not require prior authorization if a vocational referral has been made. However, it does require authorization in any other circumstance. This service is payable in addition to other services performed on the same day.

A **provisional JA** is a detailed evaluation of a specific job or type of job requested when a claim has not been accepted. This service requires prior authorization and will not be authorized during an open vocational referral. A provisional JA must be conducted in a manner consistent with the requirements in WAC 296-19A-170. The provider assigned to or directly receiving the authorization from the referral source is responsible for all work performed by any individual on the job analysis.

Code	Report/Form	Maximum Fee	Special notes
1038M	Review of Job Descriptions or JA	$33.55	**Must be requested by insurer, State Fund employer or vocational counselor.** Payable to attending doctor, IME or consultant. Limit of one per day.
1028M	Review of Job Descriptions or JA, each additional review	$ 16.78	**Must be requested by insurer, State Fund employer or vocational counselor.** Payable to attending doctor, IME or consultant. Bill to the department (see Provider Bulletin 96-10).

VEHICLE, HOME AND JOB MODIFICATIONS

Vehicle, home and job modification services require prior authorization. Refer to

Provider Bulletin 96-11 for home modification information and Provider Bulletin 99-11 for job modification and pre-job accommodation information.

Code	Description	Maximum Fee
8914H	Home modification, construction and design	Maximum payable for all work is the current Washington state average annual wage.
8915H	Vehicle modification	Maximum payable for all work is ½ the current Washington state average wage. In the sole discretion of the Supervisor of Industrial Insurance after his or her review, the amount paid may be increased by no more than four thousand dollars by written order of the Supervisor of Industrial Insurance (RCW 51.36.020(8b).
8916H	Home modification evaluation and consultation	BR
8917H	Home/vehicle modification mileage, lodging, airfare, car rental	State rates
8918H	Vehicle modification initial evaluation or consultation	BR
8920H	Vehicle modification follow up consultation	BR
0380R	Job modification (equipment, etc.)	Maximum allowable for 0380R is $5,000 per job or job site.
0385R	Pre-job accommodation (equipment, etc.)	Maximum allowable for 0385R is $5,000 per claim. Combined costs of 0380R and 0385R for the same return to work goal cannot exceed $5,000.
0389R	Pre-job or job modification consultation (non-VRC), per 6 minutes	$ 9.41
0391R	Travel/wait time (non-VRC), per 6 minutes	$ 4.26
0392R	Mileage (non-VRC), per mile	State rates
0393R	Ferry Charges (non-VRC)	State rates

VOCATIONAL SERVICES

Vocational Rehabilitation providers must use the codes listed in this section to bill for services. For more detailed information on billing, consult the Miscellaneous Services Billing Instructions Section and Provider Bulletin 01-03.

All vocational rehabilitation services require prior authorization. Vocational rehabilitation services are authorized by referral type. The department uses six referral types: early intervention, assessment, plan development, plan implementation, forensic and stand alone job analysis. Each referral is a separate authorization for services.

The department will pay interns at 85% of the VRC professional rate and forensic evaluators at 120% of the VRC professional rate.

Early Intervention

Code	Description	Maximum Fee
0800V	Early Intervention Services (VRC), per 6 minutes	$ 7.74
0801V	Early Intervention Services (Intern), per 6 minutes	$ 6.58
0802V	Early Intervention Services Extension (VRC), per 6 minutes	$ 7.74
0803V	Early Intervention Services Extension (Intern), per 6 minutes	$ 6.58

Assessment

Code	Description	Maximum Fee
0810V	Assessment Services (VRC), per 6 minutes	$ 7.74
0811V	Assessment Services (Intern), per 6 minutes	$ 6.58

Vocational Evaluation

Code	Description	Maximum Fee
0821V	Work Evaluation (VRC), per 6 minutes	$ 7.74
0823V	Pre-Job or Job Modification Consultation (VRC), per 6 minutes	$ 7.74
0824V	Pre-job or Job Modification Consultation (Intern), per 6 minutes	$ 6.58

Plan Development

Code	Description	Maximum Fee
0830V	Plan Development Services (VRC), per 6 minutes	$ 7.74
0831V	Plan Development Services (Intern), per 6 minutes	$ 6.58

Plan Implementation

Code	Description	Maximum Fee
0840V	Plan Implementation Services (VRC), per 6 minutes	$ 7.74
0841V	Plan Implementation Services (Intern), per 6 minutes	$ 6.58

Forensic and Testimony

Code	Description	Maximum Fee
0881V	Forensic Services (Forensic VRC), per 6 minutes	$ 9.29
0882V	Testimony on VRC's Own Work (VRC), per 6 minutes	$ 7.74
0883V	Testimony on Intern's Own Work (Intern), per 6 minutes	$ 6.58
0884V	AGO Witness Testimony (VRC), per 6 minutes	$ 7.74

Travel, Wait Time, and Mileage

Code	Description	Maximum Fee
0891V	Travel/Wait Time (VRC or Forensic VRC), per 6 minutes	$ 3.88
0892V	Travel/Wait Time (Intern), per 6 minutes	$ 3.88
0893V	Professional Mileage (VRC), per mile	State rate
0894V	Professional Mileage (Intern), per mile	State rate
0895V	Air Travel (VRC, Intern, or Forensic VRC)	BR

Stand Alone Job Analysis

The codes in this table are used for stand alone and provisional job analyses.

Code	Description	Maximum Fee
0808V	Stand Alone Job Analysis (VRC), per 6 minutes	$ 7.74
0809V	Stand Alone Job Analysis (Intern), per 6 minutes	$ 6.58
0378R	Stand Alone Job Analysis (non-VRC), per 6 minutes	$ 7.74

See Provider Bulletin 03-08 for additional information.

Vocational Evaluation and Related Codes for Non-Vocational Providers

Certain non-vocational providers may deliver the above services with the following codes:

Code	Description	Maximum Fee
0389R	Pre-job or Job Modification Consultation	$ 9.41
0390R	Work Evaluation	$ 7.74
0391R	Travel/Wait (non-VRC)	$ 4.26
0392R	Mileage (non-VRC)	State rates
0393R	Ferry Charges (non-VRC)(1)	State rates

(1) Requires documentation with a receipt in the case file.

A provider can use the R codes if he or she is a:

- Non-vocational provider such as an occupational or physical therapist, or
- Vocational provider delivering services for a referral assigned to a different payee provider. As a reminder to vocational providers who deliver ancillary services on vocational referrals assigned to other providers, if the provider resides in a different firm (that is, has a different payee provider number than you), you cannot bill as a vocational provider (a provider type 68). You must either use another provider number that is authorized to bill the ancillary services codes (type 34, 52 or 55) or obtain a miscellaneous services provider number (type 97) and bill the appropriate codes for those services.

NOTE*:* These providers use the miscellaneous services billing form, but must include certain additional pieces of information on bills to associate the costs of ancillary services to the vocational referral and to be paid directly for services:

- The vocational referral ID that can be obtained from the assigned vocational provider, and
- The service provider ID for the assigned vocational provider in the “Name of physician or other referring source” box at the top of the form, and
- Non-vocational providers own provider numbers at the bottom of the form

For more information, consult Provider Bulletin 01-03 and *Miscellaneous Services Billing Instructions* (F248-095-000).

Fee Caps

Vocational services are subject to fee caps. These fee caps are hard caps, with no exceptions. The following fee caps are by referral. All services provided for the referral are included in the cap.

In the case of early intervention services, a provider may request an extension of the fee cap in cases of **medically approved** graduated return to work (GRTW) or work hardening (WH) opportunities. The extension is for **one time only per claim** and does not create a new referral.

The extension is limited to a maximum of 20 hours of service over a maximum of 12 weeks. Providers should submit bills for these services in the same format as other vocational bills.

The claim manager must authorize the extension. No other early intervention professional services (i.e., services billed using 0800V and 0801V) may be provided once the extension has been approved. You may continue to bill for travel/wait, mileage and ferry charges as normal. Use codes 0802V and 0803V to bill for GRTW and WH services provided during the extension.

Description	Maximum Fee
Early Intervention Referral Cap	$ 1,587.00
Extension of Early Intervention Referral Cap	$ 1,548.00
Assessment Referral Cap	$ 2,647.00
Plan Development Referral Cap	$ 5,302.00
Plan Implementation Referral Cap	$ 5,008.00

The fee cap for work evaluation services applies to multiple referral types.

Description	Maximum Fee
Work Evaluation Services Cap	$ 1,161.00

For example, if $661 of work evaluation services is paid as part of an ability to work assessment (AWA) referral, only $500 is available for payment under another referral type.